Medical Economics

PUBLISHED EVERY OTHER MONDAY • ISSUE OF DECEMBER 22, 1958

what makes a partnership click ?

...also in this issue

New Plan Stops Unjust Malpractice Suits

What Doctors Do About Christmas

prevents painful engorgement ***New 2-day***

TACE 25mg.

over 3,000 patient studies[1,3,4] have proved TACE 12 mg. unsurpassed[2] in prevention of painful breast engorgement. Now, these same advantages are available in a shorter term 2-day course of therapy with TACE 25 mg. capsules.[2]

recurrent engorgement and withdrawal bleeding rare[1,3,4] (just 3 cases of refilling and 9 of withdrawal bleeding among 3,251 patients), because TACE is longer acting. TACE 25 mg. retains these advantages of unique storage in body fat. All TACE forms are released gradually, like a natural hormonal secretion, even after therapy stops.

ALSO NEW TACE with Ergonovine—convenient, combination therapy for relief of painful breast engorgement *and* prevention of postpartum hemorrhage due to uterine atony.[2] (Composition: Each capsule contains TACE 25 mg. and Ergonovine Maleate 0.1 mg.)

TRADEMARKS: 'TACE WITH ERGONOVINE,' TACE

'ose for both forms: 2 capsules every six hours six doses, beginning immediately after delivery.

'lsen, R. O. et al.: Am. J. Obst. & Gynec. 65:1048, 1953.
'sen, R: O.: Concurrent administration of TACE 'onovine, Ohio State M. J. *(in press)*. 3. Bennet, ' McCann, E. C.: J. Maine Med. Assoc. 45:225, chner, E. et al.: Obst. & Gynec. 6:511, 1955.

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Medical Economics

NEWS BRIEFS

WILL THE NEW CONGRESS VOTE RADICALLY on most medical issues? Probably not, Washington observers predict. Key reason: Left-leaning members of both houses will have to buck the strong conservative influence of committee chairmen from the South.

SELL STOCK BEFORE DEC. 24 if you want to establish a 1958 gain for tax purposes. The date's moved up this year by the way the holidays fall.

M.D.s STILL MUSTN'T WORK WITH D.O.s, the A.M.A. delegates have ruled. They rejected a resolution—backed by at least 8 states—that each state society should decide its own M.D.-D.O. relationships. Instead, they asked the Judicial Council to review the problem and recommend action in June.

HOW MUCH DO DOCTORS SAVE PER YEAR? A recent survey of 100 Chicago M.D.s shows their average 1957 savings varied thus: $15,000 net income level, $2,668 savings; $25,000 net level, $4,432 savings.

NEWS BRIEFS

STEER CLEAR OF ALASKAN STOCKS, investment men are warning: It may be years before such issues are anything but a bad gamble. The only ventures most experts give a speculative chance of paying off: a few small oil firms with undrilled land holdings.

IMPLIED SLAP AT UNITED FUNDS has been withdrawn by the A.M.A. Last June, delegates urged voluntary health agencies to hold separate fund drives. Now they say they meant no slight against the United Funds; they neither approve nor disapprove of voluntary agencies' joining united campaigns.

GOT A SIZABLE CHUNK OF CASH TO INVEST? Then look into the new Small Business Investment Companies. Their purpose: to pump long-term private capital into promising small businesses. Their advantages: favorable tax treatment by Uncle Sam, plus a chance to get stock in a business that may boom. Chief drawback: They're risky. Chances of making a mint may not be as good as chances of losing your shirt.

LAWYERS WHO USE GRUESOME COURT DISPLAYS to win outsize damage awards from juries apparently can't take much medical realism themselves. When films of an actual spinal operation were shown at a recent seminar of the National Association of Claimants' Compensation Attorneys, one lawyer had a heart attack; two others passed out cold.

NEWEST CULT: "REFLEXOLOGISTS." They've reportedly taken gullible South Dakotans for $3,000,000. Their "therapy": massaging the soles of patients' feet.

"LET'S LEARN TO LIVE WITH CLOSED-PANEL PLANS," was the surprising consensus of most A.M.A. delegates this month. They tabled a report summing up a 4-year study of such plans. But they passed—without a murmur—several motions indicating "attitudes toward the free choice of physician and the closed-panel system may be undergoing an evolutionary change," and saying medicine needs "a reassessment of [its] previous...attitude toward these plans."

REDUCE YOUR FEES TO LOW-INCOME PATIENTS OVER 65, the A.M.A. delegates urged doctors this month. Reason: to "permit the development" of low-premium voluntary health insurance for such patients.

DOCTORS' HELP IS URGENTLY NEEDED in tracing people who got radiation poisoning in the '20s, reports Dr. Samuel Clark of the Massachusetts Institute of Technology. These people are wanted for a current study of the long-term effect of radiation on humans. It's thought that 2,000 luminous-dial painters and several hundred patients who were treated with radium compounds prior to 1930 are still living. Doctors who've seen such cases should notify M.I.T.'s Radioactivity Center at Cambridge, Mass.

$500 *for the one best original article written by a physician and found acceptable for publication*
$300—$100 *for other original articles written by physicians and found acceptable. . .*

"For distilling something valuable out of your practice-connected experiences and putting it in writing for the benefit of doctors everywhere. . ."

Eighteen physicians won that citation last year, along with cash prizes like those listed above. Now here's **your** chance.

Some evening soon, some week-end, or any time before Jan. 1, 1959: **Write up your ideas** on one carefully limited aspect of any broad subject in our field—fees, for example, or practice management, or professional relations with other doctors.

Document your ideas with examples, anecdotes, and cases in point drawn from your own experience. The more such documentation, the better your chance of winning.

Send your article to the Awards Editor, MEDICAL ECONOMICS, Oradell, N. J.—the sooner, the better. Send in more than one article if you wish.

Please note: Manuscripts should be typed, double-spaced, on one side of the paper only, and accompanied by a self-addressed envelope and return postage. Awards are intended for articles between 1,000 and 3,000 words long. (Shorter or longer articles, if found acceptable, will be paid for at regular rates.) The editors of this magazine will be the judges; their decisions will be final.

in asthma

when emotional stress is a complicating factor

'Thorazine' by injection (ampuls or multiple dose vials) often provides immediate relief from severe attacks.

'Thorazine' Spansule† capsules q12h provide sustained, 24-hour protection against emotional stress that can precipitate attacks.

'Thorazine', in any dosage form, promotes sound sleep without respiratory depression.

THORAZINE* one of the fundamental drugs in medicine
chlorpromazine, S.K.F.

Also available: Tablets, syrup and suppositories

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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, DEC. 22, 1958

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▮ a reliable defense against monilial complications

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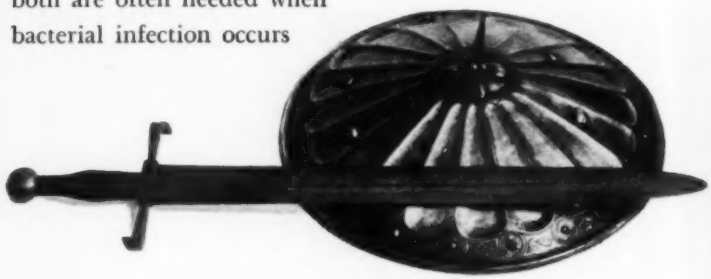
both are often needed when bacterial infection occurs



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for protection against monilial complications Mysteclin-V contains Mycostatin

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a vital measure of protection against the "little strokes"

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THE CAPILLARY-PROTECTIVE FACTORS

*Gale, E. T., and Thewlis, M. W.: Geriatrics 8:80, 1953.

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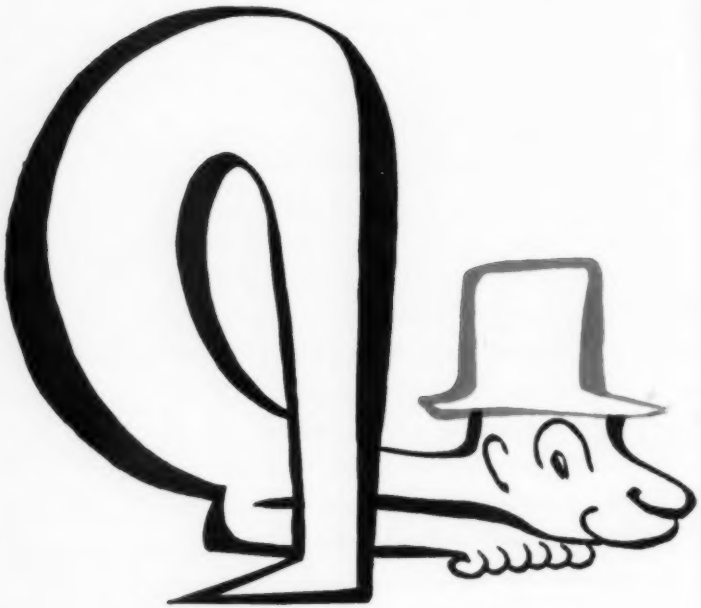

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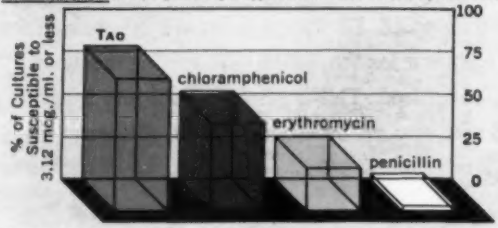
CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were Staph. aureus and Staph. albus. TAO has its greatest usefulness against the common infections caused by organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, Hemophilus influenzae.

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to TAO, erythromycin, penicillin and chloramphenicol.[1]



REACTIONS:

(a) adults	(b) children
Total—9.2% (20 out of 217)	Total—0.6% (1 out of 167)
Skin rash—1.4% (3 out of 217)	Skin rash—none
Gastrointestinal—7.8% (17 out of 217)	Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective.

Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: TAO Capsules—250 mg. and 125 mg.; bottles of 60. TAO for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: Antibiotics & Chemother. (Aug.) 1958. 2. English, A. R., and McBride, T. J.: Antibiotics & Chemother. (Aug.) 1958. 3. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy (Aug.) 1958. 4. Celmer, W. D., et al.: Antibiotics Annual 1957-1958. New York, Medical Encyclopedia, Inc., 1958, p. 476.

Letters

Social Security Poll

SIRS: Your poll indicating that over 56 per cent of doctors favor Social Security disturbs me deeply. If we're to oppose socialism, let's do so. Let's not fool ourselves into believing we can select just those aspects of socialism we want and reject the rest. How can we tell Congress we're against the Forand bill, yet say we want Social Security?

Advocates of this program argue that since 90 per cent of the population have it, we should too. But a majority isn't necessarily the thinking segment of a population. If our founding fathers hadn't stood firm for their principles, even though in a minority, the United States would never have become the nation it is.

Physicians who are insecure and must be coddled should try the Public Health Service or the Armed Forces. They'll retire you on a good pension, and you won't have to work nearly so hard to get it.

George M. Nipe, M.D.
Harrisonburg, Va.

SIRS: . . . It's wrong to look on Social Security as a handout. It's an earned, paid-for pension. And it forces a lot of people to save for their old age instead of winding up on charity.

Howard D. Stuckey, M.D.
Cairo, Ill.

SIRS: . . . Certainly we're already paying high taxes to support Social Security. But if we should come under the program, it would mean more money down the drain, over and above our regular taxes.

Social Security is no bargain. The same benefits can be bought with less money through life insurance with a family-income rider . . .

Ronald O. Germain, M.D.
Attleboro, Mass.

SIRS: You report our profession now shows a kindlier attitude toward Social Security than in your poll of two years ago. How long will polling of us on this notion continue?

If, by our own popular vote or through the manifestly kind intentions of Congress, we should come to enjoy the benefits of this compulsory relationship with the custodial state, will periodic surveys

Letters

of our fickleness in the matter continue? . . .

Walter C. Babcock, M.D.
Alameda, Calif.

Unjust to Adjusters?

SIRS: One of your correspondents charges that most insurance adjusters get half of any amount they can save the insurance company. That's not only untrue; it's illegal in the doctor's home state, Louisiana, where one section of the insurance law reads: "No insurer shall pay to any insurance adjuster . . . any portion of the amount saved . . . through the efforts of said adjuster . . ."

I'd be the last to insist that every adjuster settles every claim fairly. But most adjusters are just as honest as most medical men. The fact that only a small percentage of cases have to go to court is proof that the great majority of insurance companies and their adjusters settle claims promptly and justly.

Ben H. Mitchell
President, Employers Casualty Co.
Dallas, Tex.

Charity and Taxes

SIRS: I agree with those who dislike the compulsion of United Fund campaigns. Further regimentation of giving isn't needed. Internal Revenue Service regulations already encourage benefaction to recognized organizations only. So the joy of giving freely to needy persons and unsanctioned causes has been replaced by the satisfaction of income tax deductions.

The physician has stood up for free choice of doctor. Let him also stand up for free choice of beneficiary.

Ralph D. Bacon, M.D.
President, Pennsylvania Division,
American Cancer Society
Erie, Pa.

SIRS: . . . Recently the Columbus (Ohio) Academy of Medicine completed a thorough survey of thirty-eight voluntary health agencies in Columbus and Franklin Counties. Nineteen were United Appeals participants, nineteen were not. As a result of the study, the Academy has recommended that *all* such agencies join United Appeals.

M.D., Ohio

The Younger the Better?

SIRS: Dr. Mary B. Spahr accuses young doctors of shirking their responsibilities. I wish to take exception. In my experience as an interne, it's the younger doctors—often those in high positions—who consistently take house calls and accept consultations that the older men refuse.

My toughest job in a hospital

- postoperatively
- in pregnancy when vomiting is persistent
- following neurosurgical diagnostic procedures
- in infections, intra-abdominal disease, and carcinomatosis
- after nitrogen mustard therapy

for nausea and vomiting

VESPRIN

Squibb Triflupromazine

- provides prompt, potent, and long-lasting control
- capable of depressing the gag reflex
- effective in cases refractory to other potent antiemetic agents
- may be given intravenously, intramuscularly and orally
- no pain or irritation on injection

ANTIEMETIC DOSAGE:
Intravenous: 8 mg. average single dose
Dosage range 2-10 mg.
Intramuscular: 15 mg. average single dose
Dosage range 5-15 mg.
If subsequent parenteral dose is needed, one-half the original dose will usually suffice
Oral: 10-20 mg. initially; then 10 mg. t.i.d.

SUPPLY:
Parenteral solution – 1 cc. ampuls (20mg./cc.), 1 cc. multiple dose vials (20 mg./cc.)
Oral tablets – 10 mg., 25 mg., 50 mg., in bottles of 50 and 500

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Squibb Quality – The Priceless Ingredient

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Letters

emergency room occurred recently, when I had to calm down the family of a woman with a not-too-serious nosebleed while we were waiting for the ENT man. He'd told the family to take her at once to the emergency room, where he'd be waiting. He got there four hours later, vaguely apologizing for having been "busy at home."

I'm sure the four-hour wait lowered that family's respect for the medical profession. And the doctor was an older, well-established man.

M.D., New York

SIRS: The world is full of good people, bad people, and indifferent people. What's wrong with young doctors? The same thing that's wrong with old doctors. There are considerate people and inconsiderate, polite and impolite, moral, amoral, and immoral. And, of course, some of these people are doctors.

Times change, but people—and doctors—don't. If anyone thinks that doctors beginning practice today are any different from those who began years ago, let him read Fulton's biography of Cushing, Cushing's biography of Osler, A. J. Cronin's novels, etc., etc., etc.

M.D., Indiana

END

in all diarrheas

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MORE THAN
16 MILLION DOSES
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"Why, she hasn't eaten this way in months."

"And she looks like a million."

Wetzel et al. found that "clinical changes after B_{12} administration were those of increased physical vigor, alertness, better general behavior, but above all, a definite increase in appetite."

—*Science* 110:651

In another study, Chow compared children to whom B_{12} had been administered orally with a control group. He found that "the mean gain in body weight of the experimental group was practically twice that of the control group."

—*J. Nutrition* 43:323

The value of B_1 in combating anorexia has been long established.

TROPHITE* for appetite

The delicious high potency combination of

B_{12} (25 mcg. per teaspoonful)
B_1 (10 mg. per teaspoonful)

Smith Kline & French Laboratories, Philadelphia

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Quiactin for quieting

(oxanamide)

(one 400 mg. tablet q.i.d.)

QUIACTIN provides greater tranquility, yet avoids the drowsiness that causes patient discomfort or oversteps the bounds of safety.[1] Work, and other normal activities, continue with no drop in efficiency.[2] Structurally, QUIACTIN is a glycidamide... atom by atom, a completely new tranquilizer, prolonged in activity, nontoxic, noncumulative and free of withdrawal symptoms. QUIACTIN will not deepen depression if it is present.

1. Proctor, R. C., Southern Psychiatric Assoc. Meeting, October 7, 1957. 2. Feuss, C. D. and Gragg, L. Jr.: Dis. Nerv. Sys. *18*:29; 1957.

TRADEMARK: QUIACTIN®

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Another Exclusive Product of Original Merrell Research

nasal and paranasal congestion and control secondary invaders

Now, a single unique preparation, Trisulfaminic, can provide dramatic relief from congestion, and at the same time protect the patient from secondary bacterial invaders. Often within minutes of the first dose, congestion begins to clear; the patient can breathe again.

Trisulfaminic is particularly valuable for the "almost well" patient who is recovering from influenza but is left with congested nasal and bronchial passages. And for patients with purulent rhinitis, sinusitis or tonsillitis, combination therapy with Trisulfaminic offers a most realistic approach to total treatment.

Oral Decongestant Action. Through the action of Triaminic, nasal patency is achieved rapidly and dramatically. Adequate ventilation helps eliminate mucus-harbored pathogens. And because Trisulfaminic is administered *orally*, there is no problem of rebound congestion, no pathological change wrought in the nasal mucosa.

Wide-Spectrum Action. Secondary bacterial infections, which are always a threat in upper respiratory involvement, are forestalled by the wide-spectrum effectiveness of triple sulfonamides. This added antibacterial protection makes Trisulfaminic highly useful in treating the debilitated patient who is prone to lingering or frequently recurring colds.

Trisulfaminic *tablets and suspension*

TRIAMINIC PLUS TRIPLE SULFAS

Each Tablet and each 5 ml. teaspoonful of Suspension contains:

Triaminic®	25 mg.
(phenylpropanolamine HCl	12.5 mg.;
phenitramine maleate	6.25 mg.;
pyrilamine maleate	6.25 mg.)
Trisulfapyrimidines U.S.P.	0.5 Gm.

Dosage: Adults—2 to 4 tablets or teaspoonfuls initially, followed by 2 tablets or teaspoonfuls every 4 to 6 hours until the patient has been afebrile for 3 days. Children 8 to 12 years—2 tablets or teaspoonfuls initially, followed by 1 tablet or teaspoonful every 6 hours. Younger children—dosage in proportion.

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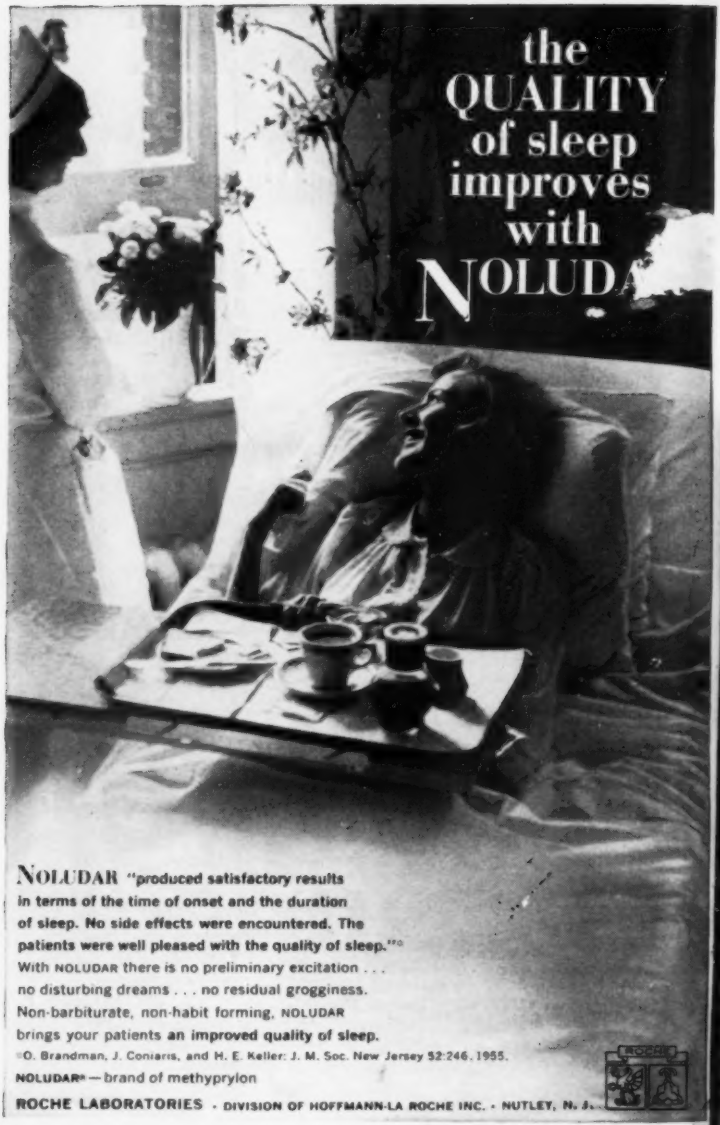

NOLUDAR "produced satisfactory results in terms of the time of onset and the duration of sleep. No side effects were encountered. The patients were well pleased with the quality of sleep."[1]

With NOLUDAR there is no preliminary excitation . . . no disturbing dreams . . . no residual grogginess.

Non-barbiturate, non-habit forming, NOLUDAR brings your patients an improved quality of sleep.

[1]O. Brandman, J. Coniaris, and H. E. Keller: J. M. Soc. New Jersey 52:246, 1955.

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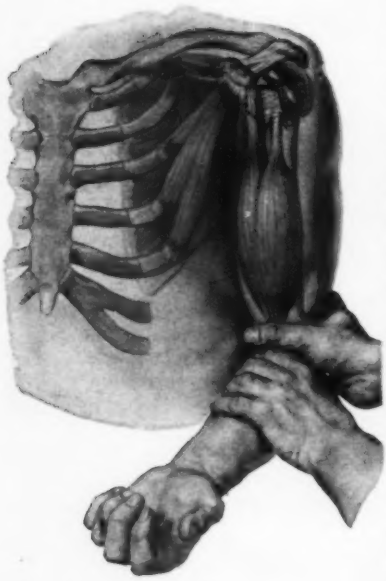


NEW INDICATION:

Parenteral Priscoline® relieves bursitis pain in over 90% of cases[1]

Frankel and Strider[1] report: "Intravenous Priscoline gave excellent to good results in over 90% of our cases."

"Priscoline hydrochloride intravenously is an effective agent in the treatment of acute and recurrent acute subdeltoid bursitis."

The 150 patients in this study were given 1 ml. (25 mg.) Priscoline, by intravenous injection, daily from 1 to 3 days. Excellent results (relief gained immediately or within 24 hours; painless rotation of arm) were achieved in 71 patients. Good results (no sedation required; partial movement of arm without discomfort) were obtained in 68 patients. Eleven patients had no relief.

Patients' ages ranged from 22 to 85 years. Calcification was present in varying degrees in 82 cases. Sixty-nine patients reported previous attacks and had been treated unsuccessfully with X-ray, hydrocortisone and other agents.

The authors suggest it is the sympatholytic action of Priscoline which relieves pain by chemical sympathetic block. Further, "Priscoline may, through its vasodilating ability, promote the transport of calcium away from the bursa."

"We can especially recommend its use in cases where X-ray therapy or local injection of hydrocortisone has failed."

1. Frankel, C. J., and Strider, D. V.: Presented at Meeting of American Academy of Orthopaedic Surgeons, New York, N. Y., Feb. 3, 1958.

SUPPLIED: MULTIPLE-DOSE VIALS, 10 ml., 25 mg. per ml.

Also available: TABLETS, 25 mg.; ELIXIR, 25 mg. per 4-ml. teaspoon.

PRISCOLINE® hydrochloride (tolazoline hydrochloride CIBA)

Illustration by F. Netter, M.D., from CLINICAL SYMPOSIA 10: Cover (Jan.-Feb.) 1958.

2/2587MK

CIBA
SUMMIT, N. J.

News · News · New

'Stop Sensationalizing News On Cancer,' M.D.s Ask

Have you ever seen a cancer patient who believed a cure was almost at hand because he'd just read a misleading newspaper report about great strides in cancer research? Four doctors who have seen such patients recently told a major newspaper just what effect its cancer stories were having on laymen. The doctors got this reply: The stories will keep appearing.

Drs. Roger Lester, Dane R. Boggs, Richard K. Shaw, and Martin E. Liebling told The Washington (D.C.) Evening Star they objected to the paper's "misleading headlines," "generalizations based on [findings] of limited importance," and front-page reports of research before anything's known of its "applicability to patients."

As an example, they pointed to a story the Star had headlined "New Advances Spur Cancer Cure Hopes." Said the doctors: "An informed individual carefully analyzing the phraseology . . . could not be misled. Unfortunately, the same cannot be said for the casual lay reader."

Using the front page to publicize research prematurely "only confuses the lay reader," the doctors continued. "Our patients and their relatives, whose hopes are raised unnecessarily . . . are cruelly disillusioned . . . when confronted with the facts."

The editors printed the doctors' letter, but wouldn't promise to change their brand of journalism. "The danger of oversimplification is inherent in science writing for popular consumption," they said.

"We concede that reports of progress in medical research may raise unrealizable hopes in the minds of some patients. On the other hand . . . the article in question was presented factually and without sensationalism . . . The Star does not believe that it would be serving the public interest by not publishing a story of this nature."

'County Medical Societies CAN'T Discipline Doctors'

Why does organized medicine tangle so often with union health plans over patients and fees? One trouble may be the profession's own inability to discipline incompetent or dishonest doctors, the editor of a

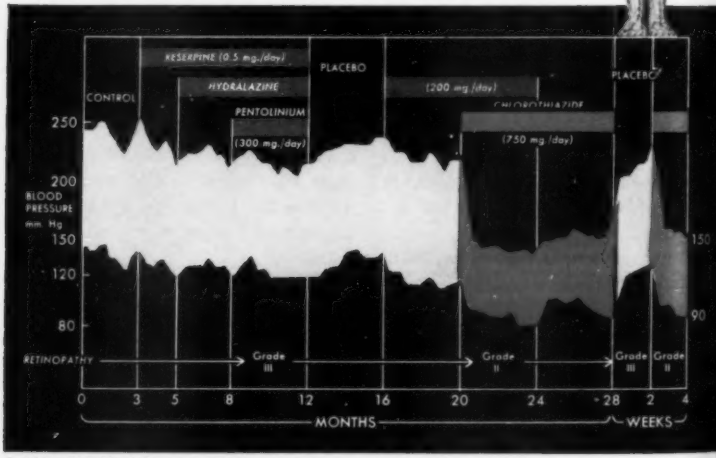
Investigator after investigator reports the

Wilkins, R. W.: New England J. Med. **257**:1026, Nov. 21, 1957

"Chlorothiazide added to other antihypertensive drugs reduced the blood pressure in 19 of 23 hypertensive patients." "All of 11 hypertension subjects in whom splanchnicectomy had been performed had a striking blood pressure response to oral administration of chlorothiazide " " . it is not hypotensive in normotensive patients with congestive heart failure, in whom it is markedly diuretic; it is hypotensive in both compensated and decompensated hypertensive patients (in the former without congestive heart failure, it is not markedly diuretic, whereas in the latter in congestive heart failure, it is markedly diuretic). . . "

Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166**:137, Jan. 11, 1958.

"Chlorothiazide (maintenance dose, 0.5 Gm. twice daily) added to the regimen of 73 ambulatory hypertensive patients who were receiving other antihypertensive drugs as well caused an additional reduction [16%] of blood pressure." "The advantages of chlorothiazide were (1) significant antihypertensive effect in a high percentage of patients, particularly when combined with other agents, (2) absence of significant side effects or toxicity in the dosages used, (3) absence of tolerance (at least thus far), and (4) effectiveness with simple 'rule of thumb' oral dosage schedules."



In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension,"
Hollander, W. and Wilkins, R. W.: Boston Med. Quart. **8**: 1, September, 1957.

MERCK SHARP & DOHME Division of MERCK & CO., INC., Philadelphia 1, Pa.

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hospital journal declares. It's time to take the policeman's job away from county medical societies, because that's the level where "action against a bungler or swindler . . . is least likely to occur," says Robert M. Cunningham Jr., editor of The Modern Hospital.

Local loyalties among doctors are partly to blame for "open warfare" between the A.M.A. and the United Mine Workers Welfare and Retirement Fund, Cunningham maintains. "U.M.W. charges that some Fund beneficiaries were being hacked up and some Fund treasuries being raided [by doctors] are too well documented to be ignored," he says. Therefore, "the conflict might have been avoided—or made less abrasive—if the medical societies concerned had taken steps to discipline members charged by the union with being incompetent or dishonest . . .

"Why didn't the county medical societies [take] some action against at least the worst offenders?" he asks. "The fact is that members of a county medical society are always reluctant to take the initiative in disciplining one of their own colleagues, especially in small communities where all the doctors know one another."

What Cunningham suggests to take the place of the present system is "some revision of the jurid-

ical process that will permit action against a known or suspected offender to be initiated from afar. Then Dr. A, knowing well that Dr. B is something of a sinner, can still sit at his side in the locker room and say to his friend, 'Joe, they can't do this to you!'

"If medicine is going to keep its few graspers and fumblers from poisoning the well," he warns, "*somebody* has to do it to Joe. In most cases his friends at home aren't going to and shouldn't have to . . .

"The ultimate solution," Cunningham concludes, "is a central judiciary system that will take responsibility for initiating investigation and action on legitimate complaints. Local medical societies would lose a little autonomy, but it is better to lose autonomy than [to lose] respect. The way things are going now, when Hippocrates is mentioned, somebody always laughs."

'Fee-for-Service Fetish' Analyzed by U.M.W.

Foes of private medicine are still using the Consumer Price Index to jab at doctors. The United Mine

THE RATIONALE FOR THE USE OF VITAMINS IN FORESTALLING INFECTIONS

Many clinicians believe that good nutrition plays a significant role in preventing bacterial infections, and that immunity depends on adequate vitamin levels. Tisdall[1] states that "a low intake of a number of vitamins, a low intake of minerals, and a change in the quality of protein can all lower resistance to infection."

Other studies show the important role of the B vitamins in antibody formation. Thus, *Nutrition Reviews*[2] reports: "Present evidence indicates that certain B vitamins, notably pyridoxine, pantothenic acid and folacin, play a significant role in antibody synthesis." According to Pollack and Halpern,[3] "Under-nutrition leads to increased susceptibility to infection and decreased resistance to established disease." And "vitamin deficiency states also may adversely influence circulating antibodies."

Halpern[4] reports that "good nutrition is important for optimal resistance to infection, for a superior tissue capability to cope with disease and injury, and for maximum antibody production . . . nutrition participates in the prophylaxis against most acute infections . . ."

And while MacBryde[5] feels that evidence is lacking to support the view that a higher than normal intake of vitamins will improve resistance to infection, he also states: "Restoration of nutrition to normal exerts a favorable influence on practically all disease conditions . . . Often the outcome will depend more upon the correction of the malnutrition than upon any therapy directed toward the malady."

THERAGRAN

SQUIBB VITAMINS FOR THERAPY

now expanded to include additional essential vitamins—

and at no extra cost to your patients

Each Theragran Capsule supplies:

Vitamin A	25,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Thiamine Mononitrate	10 mg.
Riboflavin	10 mg.
Niacinamide	100 mg.
Ascorbic Acid	200 mg.
Pyridoxine Hydrochloride	5 mg.
Calcium Pantothenate	20 mg.
Vitamin B_{12} Activity Concentrate	5 mcg.

Dosage: 1 or more capsules daily as indicated.

Supply: Family Packs of 180. Bottles of 30, 60, 100 and 1,000.

Also Available: THERAGRAN Liquid, bottles of 4 ounces; THERAGRAN Junior bottles of 30 and 100 capsules; and THERAGRAN-M (Squibb Vitamin Minerals for Therapy), bottles of 30, 60, 100 and 1,000 capsule-shaped tablets.

References: 1. Tisdall, F. F.: Clinical Nutrition, ed. by Joliffe, N.; Tisdall, F. F., and Cannon, P. R.: Paul B. Hoeber, Inc., New York, 1950, p. 748. 2. Nutrition Reviews, *15*:47, (Feb.) 1957. 3. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 18. 4. Halpern, S. L.: Ann. N. Y. Acad. Science *63*:147, (Oct. 28) 1955. 5. MacBryde, C. N.: Signs and Symptoms, J. B. Lippincott Co., Phila., 3rd Ed. 1957, p. 818.

SQUIBB *Squibb Quality—The Priceless Ingredient*

Workers recently were told by headquarters that "the fee-for-service fetish of the American Medical Association" is "a major factor contributing to the high cost of medical care."

Members of the U.M.W. were reminded that the index shows that "no item in the family budget . . . has risen as much in cost as medical care" in the last ten years. What's more: "To many Americans, who are not protected by such plans as the [U.M.W. Welfare and Retirement] Fund, it can safely be said that the present burden of medical care is almost intolerable from a financial standpoint."

The villainy of fee-for-service medicine as seen by the Mine Workers is its "temptations of unnecessary procedures and more prolonged patient treatment." The U.M.W. noted that George Bernard Shaw put his finger on this more than fifty years ago, when he wrote:

"That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair . . . And the more appalling the mutilation, the more the mutilator is paid. He who corrects the ingrowing toenail receives a few shillings; he who cuts your inside out receives hundreds of guineas."

After quoting G.B.S. with relish, the U.M.W. declared that its health program and other closed-panel plans "have literally been forced . . . to set up programs of physician selection" so they can "have some control over the amounts of fees to be paid to physicians."

'Incomplete' Insurance Form Lands Doctor in Court

A doctor wrote on a hospitalization insurance form that his patient had pneumonia. Six months later, the patient died of lung cancer. Because his report hadn't said anything about the latter disease, the doctor recently found himself faced with a $10,000 suit charging "gross fraud."

Here's the story of the case and its outcome:

Dr. Ellsworth H. North Jr. of Elizabeth City, N.C., suspected a new patient had pulmonary tuberculosis or possibly bronchogenic carcinoma. The man complained of a hacking cough and chronic fatigue. He told Dr. North that he recently had been treated by another doctor for respiratory infection, which Dr. North thought had been pneumonia. *More*

Dr. North hospitalized the patient, then had him discharged when tests showed no evidence of tuberculosis. He told the man to return in ten days for another check-up.

Meanwhile, the patient asked the physician to fill out his hospitalization insurance form. Dr. North wrote that the ailment was "pneumonia—type uncertain," that there was no indication of previous symptoms, and that the cause of the condition could be attributed to "nothing specific."

When the patient returned, Dr. North found that his congestion had apparently improved. But two months later, the patient was admitted to a hospital in another state. There his condition was diagnosed as carcinoma of the lung. He died several months later.

During all the foregoing, the Reserve Life Insurance Company paid out more than $1,600 for the man's hospital bills. Under the terms of its policy, the company could have avoided payment if it had known that either cancer or tuberculosis were suspected. So the insurance company sued Dr. North for $10,000 charging he had misrepresented the patient's condition.

Not so, said two Federal courts. And now the U.S. Supreme Court has refused to review their decisions. In ruling for the doctor, the

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Court of Appeals made these points:

¶ Although Dr. North's records list the diagnosis as "probable pulmonary tuberculosis" and "possible bronchogenic carcinoma," tests ruled out tuberculosis, and cancer was only suspected. Furthermore, while the records didn't specify pneumonia, certain symptoms of pneumonia were listed.

¶ The insurance company's form "did not ask the doctor to list diseases which had been shown not to exist or which were only suspected."

¶ Dr. North, like any physician, "was bound to answer the questions honestly and with reasonable care." But the insurance company hadn't proved that the doctor's statement was made "either with knowledge of its falsity or with reckless disregard for its truth."

How The Price Squeeze Has Hit Medical Men

Doctors are victims of a "narrowing margin of profit," according to Dr. J. W. St. Geme of Los Angeles. And he's got figures to prove it. They're from the local Moore-White Medical Clinic, and they cover the last ten years.

During this period, the numbers and specialties of the clinic's medi-

clinical evidence from

1,238,532

patient-days on Decadron –

before a single prescription was written!

When you write your first prescription for DECADRON*, consider its remarkable record prior to its release.

DECADRON (dexamethasone)—on a milligram basis the most effective of all anti-inflammatory corticosteroids—is the unique product of MERCK SHARP & DOHME, pioneer and leader in corticosteroid research.

DECADRON was first synthesized in 1957. . . . In June and August, 1958, impressive clinical reports were published and presented to the medical profession[1,2,3,4,5]. . . with thousands of cases still to be published.

But only now—more than a year later—DECADRON is being released for general practice. During that year DECADRON was undergoing comprehensive and rigorous clinical trials by leading investigators throughout the United States. More than 1,500 patients, with every known indication for corticosteroid therapy, were treated with DECADRON and observed closely for periods up to 12 months. Only now, after the completion of a thorough objective evaluation of all the preliminary clinical trials, DECADRON is ready for your prescription.

Today you can prescribe DECADRON with confidence, because its many outstanding advantages have been substantiated by extensive and prolonged clinical trials.

References

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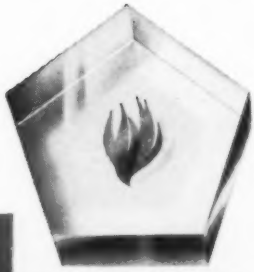
the crowning achievement of the first corticosteroid decade



Decadron*

DEXAMETHASONE

to treat more patients more effectively

Comprehensive and thorough clinical trials show that **DECADRON** on the milligram basis is the most effective of all oral corticosteroids ■ **DECADRON** is virtually free of sodium retention, potassium depletion, hypertension, or edema ■ **DECADRON** is virtually free of diabetogenic effect in therapeutic doses ■ **DECADRON** is accompanied by fewer and milder reactions than therapy with any other corticosteroid ■ **DECADRON** has not caused any new or unusual reactions ■ **DECADRON** produces neither euphoria nor depression, but restores a natural sense of well-being.

INDICATIONS: All allergic and inflammatory disorders amenable to corticosteroid therapy. CONTRAINDICATIONS: Herpes simplex of the eye is an absolute contraindication to corticosteroid therapy. DECADRON must be administered with caution in tuberculosis, other acute or chronic infections, peptic ulcer, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, pregnancy, and in the presence of psychotic tendencies. DOSAGE AND ADMINISTRATION: Transfer of patients from other corticosteroids to DECADRON may usually be accomplished on the basis of the following milligram equivalence:

one 0.75 mg. tablet of **Decadron**® (dexamethasone) replaces:

One 4 mg. tablet of	One 5 mg. tablet of	One 20 mg. tablet of	One 25 mg. tablet of
methylprednisolone or triamcinolone	prednisolone or prednisone	hydrocortisone	cortisone

SUPPLIED: As 0.75 mg. scored pentagon-shaped tablets. Also as 0.5 mg. tablets, to provide maximal individualized flexibility of dosage adjustment, since many patients achieve adequate control even on lower dosage.

Detailed literature is available on request.

cal staff remained practically unchanged, says Dr. St. Geme. But the salaries these doctors had to pay their help rose 62 per cent in ten years. Other clinic expenses rose 39 per cent. Meanwhile, fees and income increased less than 20 per cent. The accompanying tables show further details.

Is there some way to beat this sort of squeeze? The usual answers: Cut operating costs or boost cash receipts. But Dr. St. Geme comments: "It would be equally regrettable to reduce our operating costs at the expense of service to the patient, or to raise our fees beyond the ability of our patients to pay." So the usual answers have only limited application here, he believes.

Chiropractors Win a Round But Lose Another

Not long ago, a St. Louis chiropractor was paid from the public schools' accident-benefit fund for treating an injured high-school athlete. His colleagues made sure the public heard about it. They took newspaper advertisements to herald the news—and to slip in this free advice:

"Severe twists and sprains are common to those engaged in all types of sports. These injuries, if

Price Squeeze, 1947-1957

*(The following tables include examples of the economic experience of one large medical group.)**

Office Salaries, Up 62%.

Employe	Av. Salary Per Mo. in 1947	1957	% Increase
Receptionist	$180	$290	61%
Nurse	225	310	38
Medical secretary	220	360	63
Lab technician	235	450	91

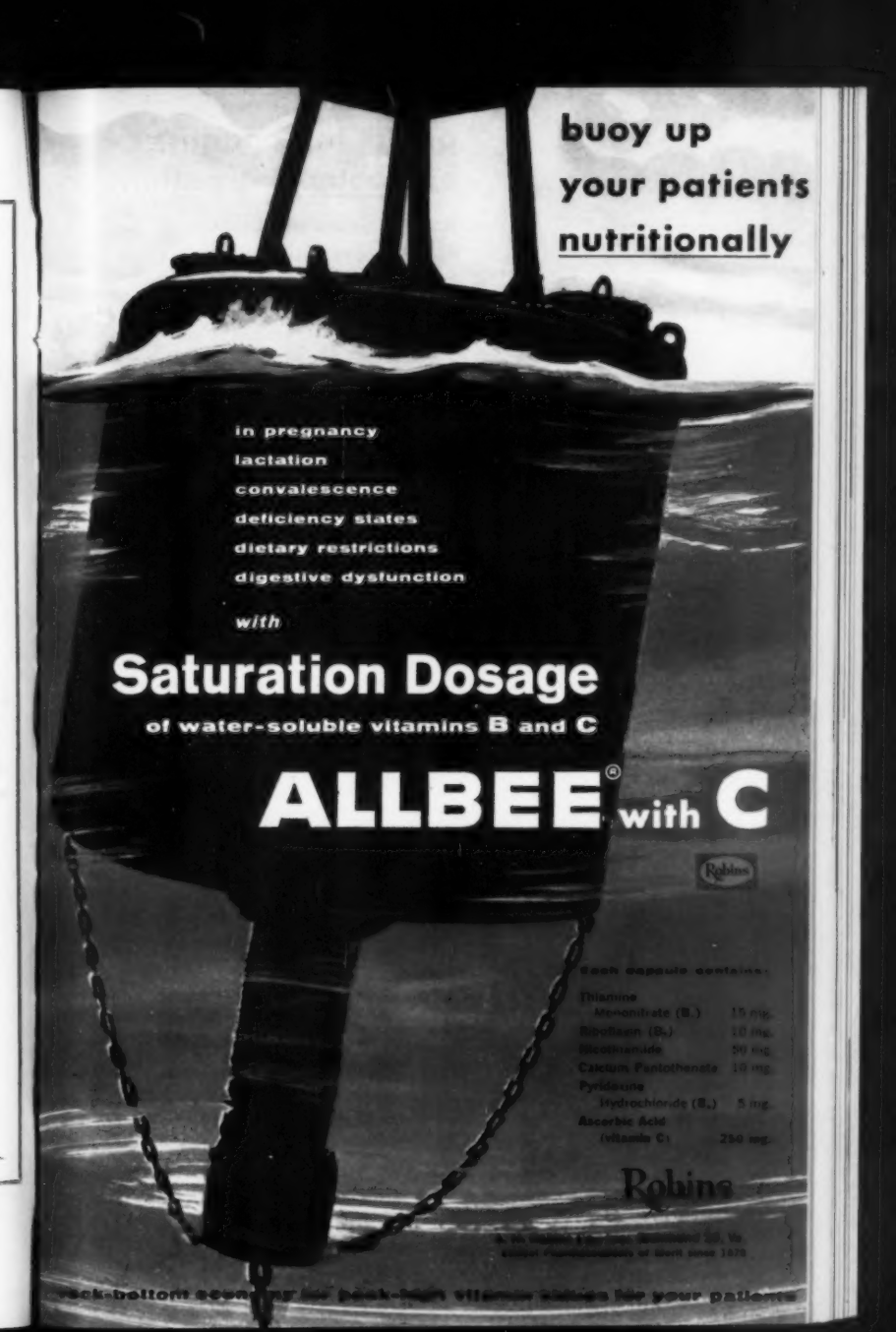
Other Expenses, Up 39%.

Item	Av. Outlay Per Mo. in 1947	1957	% Increase
Phone	$779	$1,206	54%
Office supplies	668	1,000	50
Drug supplies	1,626	2,019	24
Malpractice ins.	219	554	153

Group's Fees, Up 19%.

Service	Average Fee 1947	1957	% Increase
Office visit	$ 5	$ 6	20%
Physical examination	15	26	73
Delivery (OB)	175	225	28½
Hysterectomy	300	350	16⅔

*See accompanying text for further details.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your patients
nutritionally
in pregnancy
lactation
convalescence
deficiency states
dietary restrictions
digestive dysfunction
with
Saturation Dosage
of water-soluble vitamins B and C
ALLBEE® with C
Robins
Each capsule contains:
Thiamine Mononitrate (B1) 15 mg.
Riboflavin (B2) 10 mg.
Niacinamide 50 mg.
Calcium Pantothenate 10 mg.
Pyridoxine Hydrochloride (B6) 5 mg.
Ascorbic Acid (vitamin C) 250 mg.
Robins

not treated properly by a profession dedicated to the correction of faulty body mechanics, can lead to extremely painful nerve involvements in a short period of time..."

Medical men did their reacting in private. But they came out fighting when another pitch from the chiropractors was heard over the air. A St. Louis radio station broadcast an announcement that chiropractors would give school children a free spinal examination "as a public service." M.D.s protested to the station, and the plug quickly faded off the air.

Court Rules on When A Sickness Begins

When does an ailment actually begin? Since health insurance carriers aren't eager to pay for sickness that predates a policy, doctors get tossed that question often. But it took the state's highest court to answer it in Arkansas.

A woman there had had a dormant bony growth on the back of her head since childhood. Suddenly it became active and required surgery. When she turned over the medical bills to her insurance company, it refused to pay. The company pointed out that her insurance covered only ailments that originated after the policy went into effect. It argued that her condition had existed years before that.

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But the Arkansas Supreme Court ordered the company to pay up. The Court's view: It doesn't matter how long an ailment is latent and unnoticed. A sickness begins when it becomes active or when enough symptoms show up to permit a reasonably accurate diagnosis.

'Smokers Should Pay For Cancer Research'

Statistical studies linking lung cancer and cigarette smoking have given one eminent medical researcher an idea. Sir Macfarlane Burnet (one of the men who isolated the influenza virus) now proposes that his native Australia require a special tax stamp on every package of cigarettes. Proceeds from the sale of such stamps would be earmarked for cancer research.

Besides providing new research funds, he points out, such a tax stamp would serve as a "quiet reminder to cigarette smokers."

How to Sell Your Car To Another M.D.

If you've an old car to sell, and you think one of your colleagues might be a prospect, maybe you should advertise the way a New York doctor did recently. He posted this notice on the Albany

"Much better — thank you, doctor"

Proven in research

1. Highest tetracycline serum levels
2. Most consistently elevated serum levels
3. Safe, physiologic potentiation (with a natural human metabolite)

And now in practice

4. More rapid clinical response
5. Unexcelled toleration

COSA-TETRACYN*

GLUCOSAMINE-POTENTIATED TETRACYCLINE

CAPSULES	ORAL SUSPENSION	NEW! PEDIATRIC DROPS
(black and white) 250 mg., 125 mg. (for pediatric or long-term therapy)	(orange-flavored) 125 mg. per tsp. (5 cc.), 2 oz. bottle	(orange-flavored) 5 mg. per drop, calibrated dropper, 10 cc. bottle

COSA-TETRASTATIN*

glucosamine-potentiated tetracycline with nystatin

Antibacterial plus added protection against monilial superinfection

CAPSULES (black and pink) 250 mg. Cosa-Tetracyn (with 250,000 u. nystatin)

ORAL SUSPENSION 125 mg. per tsp. (5 cc.) Cosa-Tetracyn (with 125,000 u. nystatin), 2 oz. bottle

COSA-TETRACYDIN*

glucosamine-potentiated tetracycline-analgesic-antihistamine compound

For relief of symptoms and malaise of the common cold and prevention of secondary complications

CAPSULES (black and orange)—each capsule contains: Cosa-Tetracyn 125 mg.; phenacetin 120 mg.; caffeine 30 mg.; salicylamide 150 mg.; buclizine HCl 15 mg.

REFERENCES: 1. Carlozzi, M.: Antibiotic Med. & Clin. Therapy 5:146 (Feb.) 1958. 2. Welch, M.: Wright, W. W., and Staffa, A. W.: Antibiotic Med. & Clin. Therapy 5:52 (Jan.) 1958. 3. Marlow, A. A., and Bartlett, G. R.: Glucosamine and leukemia. Proc. Soc. Exp. Biol. & Med. 84:41, 1953. 4. Shalowitz, M.: Clin. Rev. 1:25 (April) 1958. 5. Nathan, L. A.: Arch. Pediat. 75:251 (June) 1958. 6. Cornbleet, T.; Chesrow, E., and Barsky, S.: Antibiotic Med. & Clin. Therapy 5:328 (May) 1958. 7. Stone, M. L.; Sedlis, A., Bamford, J., and Bradley, W.: Antibiotic Med. & Clin. Therapy 5:322 (May) 1958. 8. Harris, H.: Clin. Rev. 1:15 (July) 1958.

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(N. Y.) Medical College bulletin board:

"Kindly home wanted for venerable, friendly car that . . . has moderate arteriosclerosis and minimal osteoarthritis. Circulation and vigor of a car twenty years younger. Good excretory function, although a bit gassy at times. Family: Chevrolet. Vintage: 1948—a good year. Tires good, brakes new . . . wonderful clutch. No malignancy present."

Pioneer No-Fee-Schedule Health Plan Doing Fine

Many insurance men have warned that no-fee-schedule, semicomprehensive medical insurance is doomed because excessive doctors' fees and overutilization will drive it out of business.

But one of the first and biggest of these semicomprehensive health plans is heading into its fourth year amid enthusiastic cheers from both the insurance carrier and the sponsoring company.

It's the plan that covers some 260,000 General Electric employes and their families—in all, about 700,000 people. According to its latest annual experience figures, nonmaternity claims were filed by 217 out of every 1,000 covered persons during the year. Average annual payment per claimant was $204.*

These are substantial figures—but not excessively so, it's said, because of "diligent efforts of county medical societies and individual doctors to prevent abuse."

Specialists Go in for Their Own Group Life Policies

Specialists are finding that it pays to get together in their own group life insurance plans. Latest are the radiologists. Their plan works like this:

Once 1,000 or more radiologists have signed up, they'll get the group insurance without medical examinations. Their insurance carrier also agrees to pay the difference between premiums received and actual cost as a contribution to the American College of Radiology Foundation.

The radiologists borrowed the idea from the OB/Gyn. men, who already have a group plan.

Medical Society Advises When to Bill an M.D.

Are there times when you'd be guilty of professional discourtesy if you treated a colleague free? The Board of Censors of the Queens County (N.Y.) medical society thinks so. It advises local doctors

*Insurance sources say almost a third of the claims paid by the G.E. plan wouldn't have been covered under most hospital-surgical plans.

now, for the first time, **liquid** meprobamate

Equanil®

Suspension

Meprobamate, Wyeth

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acceptably flavored...

your answer to tablet problems in anxiety and tension states

- in children
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SUPPLIED: Suspension, 200 mg. per 5-cc. teaspoonful, bottles of 4 fluidounces. Also available: Tablets, 400 mg., scored, bottles of 50; 200 mg., scored, vials of 50. WYSEALS® EQUANIL, tablets, 400 mg., vials of 50.

RELIEVES TENSION—MENTAL AND MUSCULAR

PHYSICIANS' COUNCIL

Conforms to Code for Advertising

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to send their colleague a bill if he needs it:

¶ To support a legal claim for damages.

¶ To pass on to his health insurance carrier for payment.

You've undoubtedly heard before that it's all right to bill a doctor-friend who's covered by insurance.* But the Queens society spells out what could happen if you *failed* to bill him. His health insurance company (1) wouldn't have to pay and could keep "an unearned windfall," or (2) might "conceivably" send him a check anyway and place him in the "untenable position" of collecting for another doctor's services.

*As the A.M.A. Judicial Council puts it, you "may accept the insurance benefits." See "So You Think You Know What's Ethical . . ." MEDICAL ECONOMICS, Sept. 15, 1958.

Firemen Help M.D.s Solve Emergency-Call Problem

Have physicians in your area found it difficult to set up a round-the-clock emergency-call system? Doctors in one small Virginia town did, chiefly because few of the town's facilities operate on a twenty-four hour basis. But with the help of the City Council, they've recently

solved the problem by using one of the facilities that do operate day and night: the local fire department.

Henceforth, emergency calls for a doctor in Williamsburg, Va. (pop. 7,000) will go to a special phone in the firehouse. Firemen will have a duty roster of doctors, supplied by the Williamsburg-James City County Medical Society.

'What to Charge a Patient Who Has Major Medical'

Doctors have long been advised by insurance men to restrain themselves from charging high fees to patients covered by major medical policies. Now The National Underwriter offers a rule of thumb to help a doctor apply that self-restraint:

Simply charge the patient what you would have for his income group before he bought the policy, the insurance publication advises. After all, "the patient with major medical insurance is certainly no richer than he was before, and in fact is poorer by reason of the substantial premium he pays."

But then the insurance publication underlines, perhaps absent-mindedly, the dilemma the doctor's in if he follows this rule of thumb:

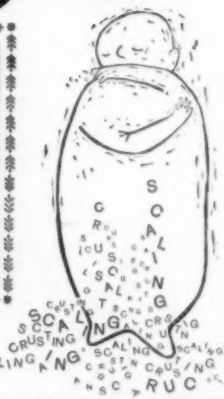
"Many patients who have [major medical] coverage might just have to leave the doctor holding the bag if they were not so heavily insured."

What Doctors Have Paid For Medical Buildings

There's a trend toward doctor-owned medical buildings, according to a spot-check in seven Midwestern states. Millard K. Mills of Professional Management Midwest reports that more than half their M.D.-clients who have constructed their own buildings have put them up since 1954.

If you're thinking of doing the same—and wondering just what you'll let yourself in for if you decide on a building of your own—probably you'll benefit from this run-down on the Midwesterners' experience:

Cost: Doctors in communities of less than 1,000 paid an average of $11 per square foot of floor space. The cost rose to a high of $19.60 in cities of 50,000 to 100,000. In still larger cities, it went down again slightly. The price of the lot in all locales averaged 11 per cent of the price of the building. *More*▶



THE IDEAL ANTIBIOTIC AND ANTI-INFLAMMATORY COMBINATION FOR INFLAMMATORY AND/OR INFECTIOUS DERMATOSES

NEO-MAGNACORT®

neomycin and hydrocortamate

TOPICAL OINTMENT

The extraordinary water-soluble dermatologic corticoid, MAGNACORT, combined with the outstanding topical antibiotic, neomycin, for superior control of inflammatory and/or infectious dermatoses.[1-6] Improvement or complete cure noted in 88% of a series, including many skin disorders notoriously difficult to treat.[5]

SUPPLIED: In 1/6-oz. and 1/2-oz. tubes, 0.5% neomycin sulfate and 0.5% hydrocortamate hydrochloride.

Also available: MAGNACORT® Topical Ointment: in 1/6-oz. and 1/2-oz. tubes, 0.5% hydrocortamate hydrochloride.

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Architects' fees: They ranged from 1 to 10 per cent, and usually were 5 or 6 per cent. For two buildings out of three, no architect was consulted.

Financing: More than half the M.D.s borrowed from banks. Seventeen per cent borrowed privately; 12 per cent borrowed from insurance companies; 10 per cent paid cash.

Four doctors out of every five got their loans at an interest rate of 4 or 5 per cent. None had to pay more than 6 per cent.

Number of doctors in a building: Sixteen per cent of the medical buildings are for one doctor only. Forty-one per cent are for two doctors. Forty-three per cent are for three or more doctors.

Space obtained: The average space in the doctor-owned buildings is 860 square feet per doctor. That's 23 per cent more space per doctor, says Mills, than their clients have who rent their offices. He comments:

"The doctor who rents seldom has an 'ideal' office. So he makes up for it—maybe even goes overboard a little—when he designs his own building." END

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Whether vaginitis is caused by Trichomonas, Monilia or Hemophilus vaginalis—alone or combined—TRICOFURON IMPROVED swiftly relieves symptoms and malodor, and achieves a truly high percentage of cultural cures, frequently in 1 menstrual cycle. TRICOFURON IMPROVED provides: a *new* specific moniliacide MICOFUR® brand of nifuroxime, the *established* specific trichomonacide FUROXONE® brand of furazolidone and the *combined* actions of both against Hemophilus vaginalis.

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High-concentration topical salicylate-menthol therapy (BEN-GAY) offers safe, penetrating relief of painful joints and muscles resulting from overexertion.

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A double-blind study[1] has reaffirmed the exceptional efficacy and safety of conservative, local treatment of chronic rheumatic disorders with BEN-GAY® (BAUME BENGUÉ), a high-concentration salicylate-menthol compound.

The local and systemic effects of BEN-GAY were evaluated by entirely objective methods in 211 subjects of both sexes suffering from various types of chronic arthritis, bursitis, neuralgia, myalgia and lumbago. Changes in range of joint motion were determined by goniometer and by flexion Topical application of BEN-GAY measurably improved articular function in 94% when physical therapy was also used, and in 61% without adjunctive treatment. Efficient absorption of salicylate through the skin was indicated by an average urinary excretion of 15 mg. in 24 hours. No ill effects were reported or observed.

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Menthol-induced hyperemia plus high local concentration of salicylate has been recently rediscovered as one of the safest and most promptly effective remedies for rheumatoid discomfort due to exposure.

This controlled study offers new evidence of the efficacy and safety of local treatment of chronic rheumatic disease with BEN-GAY, one of the safest and most reliable formulae at the physician's disposal. BEN-GAY is available in two strengths, *Regular and Children's*. THOS. LEEMING & CO., INC., 155 East 44th St., New York 17, N.Y.

[1]Brusch, C.A., et al.: Md. State Med. J.; 5:36, 1956.

***More efficient salicylate penetration* of treated area and quicker relief of pain is now made possible by water-washable, new GREASELESS-STAINLESS BEN-GAY.**

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Evidence of these advantages of Serpasil is found in reports from 450 physicians in the U.S. (part of an objective international survey* conducted by CIBA).

Reports of 871 patients treated for hypertension *with anxiety-tension* show excellent or good overall response in 74 per cent. Reports of 261 patients with tachycardia show excellent or good response in 80 per cent.

When tachycardia or marked anxiety-tension are a part of the hypertensive picture, Serpasil can help your patient in more ways than one.

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*Complete information about the results of this survey will be sent on request.

2/2604MB

WHEN POTENCY COUNTS MOST

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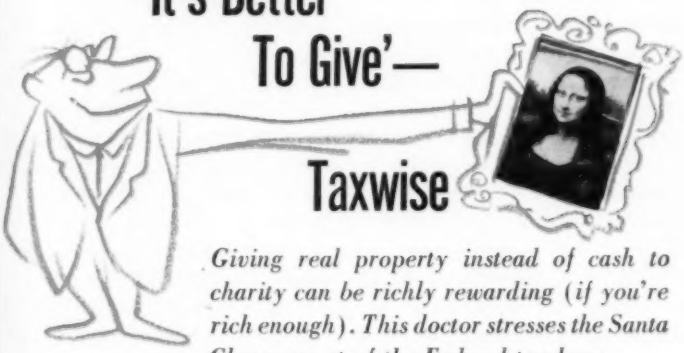
aids in the rehabilitation of severely ill or injured patients

Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, DEC. 22, 1958

'It's Better To Give'— Taxwise



Giving real property instead of cash to charity can be richly rewarding (if you're rich enough). This doctor stresses the Santa Claus aspect of the Federal tax laws

By John Bell, M.D.

The four of us shuffled through the cafeteria line, picked up our coffee, and sat down at a table. Charlie Bowdron, chairman of the doctors' committee, spoke up first.

"I want to thank all of you for your contributions toward the new hospital," he said. Then he turned to me. "You in particular, Jack," he added. "Ten thousand dollars is one hell of a lot of money, and we appreciate it."

"Don't single me out for my generosity. You may as well know the truth: I actually made a couple of hundred dollars on the deal," I volunteered, quite honestly.

Charlie's mouth opened wide. Ken Ainsworth and Will Ho-

mack held their coffee cups at half-mast, staring at me.

"I mean just that," I said, smiling. "I made more money by giving that $10,000 worth of property to the hospital drive than I'd have realized if I'd sold it and pocketed the cash."

Sound impossible? It isn't, thanks to that modern wonderland known as the Internal Revenue Code. And so I told my companions a few facts about the tax law that they should have known but didn't.

"You see," I explained, "when you give property to a charity, you can claim a tax deduction for its fair market value. And if the property is worth more now than when you bought it, you don't have to pay a tax on the capital gain.

"Take this $10,000 worth of real estate I've just deeded over to the hospital," I went on. "I paid $500 for it twenty years ago, when it was still a home for indigent gophers. If I sold the land today, I'd have to pay a tax of $2,375 on my capital gain. That would leave me only $7,625 on the sale.

"But since I gave it to the hospital, I don't have to pay a tax on the gain. And I can also claim the full $10,000 as a deduction on my income tax return. I'm in a pretty high tax bracket—78 per cent, to be exact. So that deduction is worth $7,800 in tax savings to me. That's $175 *more* than I'd have cleared by selling the land and keeping the money."

After fifteen seconds of silence the questions started pouring in.

Two Requirements

"But doesn't it work that way only if the property really jumped in value?" asked Charlie Bowdron.

"And only if you're in one of those rarefied tax brackets?" added Will Homack.

"Right on both counts," I replied.

"Well that's dandy for you," protested Ken Ainsworth. "But how many doctors own property that's gone up 2,000 per cent? And how many of us are in the 78 per cent tax bracket?"

"Not many," I conceded. "But almost every guy on this staff has some kind of property that's appreciated at least a little. And every one of us pays more in taxes than he'd like to. The same tax rules that made a profit for

me apply no matter how little the property has appreciated or what your tax bracket may be. Maybe you can't *make* money on your charitable contributions. But you *can* trim the after-tax cost considerably. Let me show you how."

My coffee was getting cold, so I took a quick sip. I noticed the others were ignoring theirs.

"Let's take you, for example, Ken," I said. "You were telling us about the $400 flier you took in a penny stock a few months ago. Now it's up to $1,000, and you plan to sell.

A Way to Save

"Instead of doing that, you could parcel out the shares among your favorite charities in place of your usual cash contributions. The charities can sell the stocks whenever they want to; so it makes no difference to them. But look at the difference it'll make to you."

I fished an old envelope out of my pocket and made a few calculations on it. "Let's say you're in the 38 per cent tax bracket," I went on. "If you sold the stock and handed the proceeds over to your charities, you'd have to pay a $228 tax on your capital gain. And the $1,000 contribution would save you $380 as a tax deduction. On balance, it would cost you $848 in after-tax dollars.

"But if you gave the stocks directly to your charities, you'd avoid the $228 tax—and still get the same $1,000 tax deduction. Your after-tax cost would be only $620."

"Very interesting," Will Homack remarked. "You say you can do this with any kind of property that's gone up in value?"

"Anything—land, securities, jewelry, paintings, even your professional equipment—as long as you're willing to get rid of it

"See any camels on the way back?"

anyway and as long as you'd have to pay a tax on your gain if you did."

"I've got an old microscope I've been meaning to sell," Charlie Bowdron put in. "It's still in good shape and should bring about $200. That's just about what I've been planning to give my medical school this year. Gee! I wonder . . ."

"Now you're getting the idea," I said. "I imagine you've fully depreciated the microscope for tax purposes. So you'd have to pay a tax on your $200 paper profit if you sold it. If you give it to your school, you'll get the same $200 deduction but avoid the tax. And the school can sell it or use it, whichever it prefers. Of course, the tax on $200 doesn't come to much. But little taxes have a way of adding up."

Two Things to Watch For

"What's the hitch?" snorted Ken. "There must be one."

I shook my head. "There isn't. That tax break was written into the law, and there's no reason why you shouldn't use it. But there are two danger points to watch for before you start handing out your worldly goods.

"The first is this: Be sure the property has gone *up* in value before you give it away, not *down*. If it has gone down, you're better off selling the property separately and giving away cash. Then you can take a tax-deductible *loss* on the drop in value in addition to the deduction for your contribution. But if you were to give the depreciated property directly to your charity, you couldn't claim a deduction for the loss."

"And?" prompted Ken.

"The other thing is that you've got to have proof of the property's fair market value. It's easy enough to establish the value of stocks; just read it off the quotations in your newspaper on the day you give them away. But you may have trouble proving the value of things like real estate, medical equipment, or paintings.

"If the amount of money involved is large, you'd better have the property appraised—and ask the appraiser for a signed statement."

Charlie Bowdron cleared his throat. I could see the question coming. So I anticipated it:

"That's right, Charlie. You can deduct the appraiser's fee too." END

A Good Way To Write Off Old Accounts

By Clayton L. Scroggins

In certain cases where the delinquent debtor can't or won't pay, canceling the debt may well bring you dividends. But the write-off requires skillful handling

Many months have passed since you last saw the patient. He's ignored bills, reminders, letters, possibly even phone calls from your office. What's your next move?

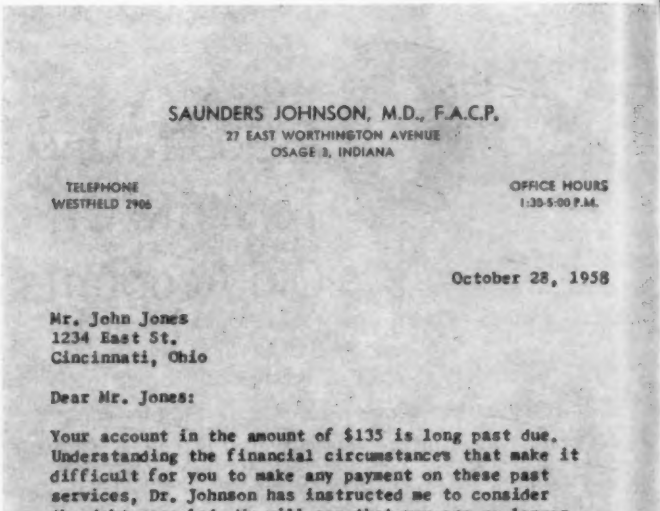
Well, you can turn the account over to professional collectors; you can bring suit against the debtor; or you can write off the account. There's nothing new I can tell you about the first two moves, but I have learned something about the third.

I frequently suggest to my physician-clients that they write off the unpaid account whenever investigation reveals that it has remained unpaid primarily because of hardship. As I see it, it's sound business to put some limit on the time, effort, and expense you invest in trying to collect from people with marginal incomes.

In such cases, with the doctor's concurrence, I usually send the patient a letter like the one that's reproduced on the following page.

"But," you may ask, "isn't it enough to stop sending bills? Why

THE AUTHOR *heads Clayton L. Scroggins Associates, a medical management firm in Cincinnati.*



SAUNDERS JOHNSON, M.D., F.A.C.P.
27 EAST WORTHINGTON AVENUE
OSAGE 3, INDIANA

TELEPHONE
WESTFIELD 2906

OFFICE HOURS
1:30-5:00 P.M.

October 28, 1958

Mr. John Jones
1234 East St.
Cincinnati, Ohio

Dear Mr. Jones:

Your account in the amount of $135 is long past due. Understanding the financial circumstances that make it difficult for you to make any payment on these past services, Dr. Johnson has instructed me to consider the debt canceled. We will see that you are no longer billed for it.

The doctor wants you to feel free, however, to call on him for any future services you may require.

Sincerely yours,

Clayton L. Scroggs

Auditor for Dr. Johnson

WRITE-OFF LETTER *clears the dead wood out of the doctor's file of long-overdue accounts. In the process, it usually brings in some checks and some referrals too. The last paragraph of the letter can be omitted if the doctor decides that he wants to close the account for good.*

should you bother to notify the patient?"

There are several good reasons for the write-off letter. For one thing, it puts a definite close to the account, thus reducing the number of meaningless entries in your books.

Then, too, in my experience, the letter often spurs at least partial payment from the debtor who's unwilling to accept charity. And even if it doesn't bring such tangible returns, it creates a growing reservoir of goodwill.

'That Wonderful Doctor'

How so? Well, in his gratitude, the patient is likely to urge his acquaintances to visit "that wonderful doctor of mine." And although such referrals should be screened carefully, there's no reason to fear that the patient's friends will be looking for write-offs too. Most people want fair treatment more than they want free rides.

Once an account has been written off and the patient notified, you're in a good position to make better arrangements for the future. At the patient's next visit, your aide may want to suggest a pay-as-you-go plan. "That way," she can explain, "you'll never again be worried by a big doctor bill hanging over your head."

There's one strong contraindication to the use of the write-off letter: I never recommend it in a case where there may be some suspicion of negligence on the doctor's part. In any such situation, obviously, the letter could turn up as Exhibit A in a malpractice suit.

On the other hand, I *do* recommend the letter in occasional cases where hardship isn't the main factor. If the patient resists all collection efforts for more than a year, and if his account is causing more trouble than it's worth, then the write-off letter can be sent *without* the final paragraph. This closes not only the patient's account, but also the doctor's dealings with him.

As a rule, the write-off letter should be sparingly used. It's designed for special cases—not for any large number of the doctor's delinquent accounts. Indeed, if sent out on too broad a basis, the letter might easily backfire.

So if you want goodwill without grief, save the write-off letter for the situations where it really applies. END

Simple New Plan Stop

By William N. Jeffers

Often the potential plaintiff backs down gracefully after this doctor-lawyer panel gives his case an impartial going-over. And the doctors are so pleased with the results that they wonder why similar programs of pre-suit testing aren't being tried in other areas. When you've read their story, you may wonder too

Plan Stops Unjust Malpractice Suits

Some malpractice suits are brought because the doctor has committed malpractice. That's obvious. It's equally obvious that a great number of suits are brought simply because the patient—and/or his lawyer—hopes to cash in on a long-shot bet.

Such hope springs eternal in most of the U. S. But it has lost its bounce in one locale. The medical community of Tucson, Ariz., has set up what may prove to be a uniquely effective barrier against trumped-up malpractice charges.

There, a year and a half ago, the Pima County Medical Society and the local bar association jointly set up a simple new procedure that screens malpractice claims before they're taken to court. A doctor-lawyer panel does the screening job. If it decides that a given claim is unjustified, the claim is unlikely to go further. But if it's clearly justified, the medical society sees to it that doctors will testify for the plaintiff.

Today, there are a good many malpractice-defense programs around the country. But none yet seems quite as potent as the Tucson plan.

Generally, such schemes take the form of a medical society committee that works with insurance advisers in an effort to decide whether to help fight or to settle claims. In California, doctors and lawyers *are* cooperating; local medical societies in metropolitan areas provide panels of specialists from which patients' attorneys may choose

expert advisers—or, if trial occurs, expert witnesses.

That's as far as the California plan goes. In Arizona, the doctors and lawyers are working together on a much broader basis. And so far, they appear to be doing a good job. Out of six cases the joint panel has handled, five were stopped in their tracks and one was settled in favor of the plaintiff.

In 1956, there were five malpractice lawsuits in Pima County. In 1957, there were none. Total so far for 1958: zero.

A Model Plan?

Obviously, no single malpractice defense scheme can answer the problem in *every* part of the country. There are too many local differences. Even so, if the uncomplicated Arizona plan continues to work well, it could become a model for many similar plans elsewhere. Doctors, lawyers, would-be plaintiffs, and the courts would all be the gainers. For of the malpractice lawsuits filed in the U. S. in recent years, less than a third have ended with court-awarded damages or with out-of-court settlements. Clearly, most of these costly, time-wasting, reputation-harming lawsuits should never have been filed.

The Tucson program is designed to prevent just such needless waste. Briefly, it operates as follows:

Who's on the Panel

The panel is drawn half-and-half from the medicolegal committees of the medical society and the bar association—up to ten members from each group. Each member now serves three years under an appointment system whereby at least two-thirds of the members will always have had at least two years' experience on the panel.

Any attorney may submit a malpractice claim to the panel via a letter to the bar association. He merely states the facts and authorizes the panel to examine the claimant's medical records.

Within forty-five days, the panel meets and hears the evidence. This is done informally, with no official record kept. Immediately after the meeting—or a second one if needed—the panel weighs the case and decides by secret, majority vote whether or not there's a "reasonable possibility" that malpractice occurred. Its conclusions are

given in writing to the plaintiff's attorney and to the physician concerned.

If the panel has decided no suit is justified, the patient's attorney doesn't file one. If the claim appears to have merit, the panel helps the plaintiff get expert witnesses. Since the medical witnesses are solicited by an official medical body, they're naturally less hesitant to testify than they might otherwise be.

The panel doesn't try to settle disputed questions. It suggests no damages. It just examines the facts to see whether there's any evidence in possible support of the plaintiff's allegations.

Confabs Are Private

Its deliberations are never made public. The number of votes pro and con isn't revealed —even to panel members. Only the decision is given, by the bailiff who counts the votes. (There's a good reason for this: If it were known a vote had been close, the attorney in the case might be tempted to go ahead and sue anyhow.)

Technically, of course, no lawyer is required to submit a case to the panel. But any reputable man who's uncertain of the merits of a given case is likely to submit it rather than risk becoming known as a "fringe" practitioner.

He isn't bound to abide by the panel's decision, either. But, in the words of the plan's official blueprint, he must have "strong and overriding reasons" to do otherwise. "Any attorney who brings a case before the panel shall weigh its conclusions in the greatest professional good faith."

How It Began

How did the Arizona plan get started? Here's the story from Dr. Ian M. Chesser, the Tucson surgeon who heads the medical society's medicolegal committee and who has been a member of the panel since its inception:

"This community has about 225 physicians. We weren't having relatively more or fewer malpractice suits than most places of our size. Still, we'd felt for some time that the situation might take a sudden change for the worse, mainly because of our large transient population of tourists.

"Fortunately, we've always enjoyed good relations with the local attorneys. So we decided we'd try to work out with them some plan to screen malpractice

cases before they got to be lawsuits. The bar association was receptive. They agreed with us that the mere filing of a malpractice action, no matter how groundless, could do real harm to a doctor's reputation and practice. And we agreed with them that people with legitimate grievances against physicians usually had a terrible time getting other doctors to testify for them.

"It was clear that any plan must try to improve both situations. With this in mind, committees from the medical society and the bar association sat down together and got to work."

After dozens of meetings, the original plan for a "Joint Screening Panel" was drawn up. It was approved by both organizations in April, 1957.

Since then, in the light of experience, the plan has been refined and strengthened in several respects. For instance, the initial program didn't require both the patient and the doctor to appear before the panel at the same time. It now does. Reason: It was discovered that whenever both parties did happen to turn up together, each of them got a clearer idea of the other's case.

It was also found that if panel members were allowed to toss questions at the patient and the doctor informally, the meetings could get a bit riotous. So, after

"I trust you didn't forget the angostura."

a few untidy sessions, the rules were changed to allow only the chairman to ask questions, these to be written out and given him by the members. This procedure keeps the sessions orderly. And it removes any tinge of the personal from all questions.

In the course of its activities, what sort of unjustified claims has the panel screened out? Here are some examples:

Suits That Weren't

A patient suffered a hernia following a cholecystectomy. He wanted to sue the surgeon because he'd somehow got the impression the hernia wouldn't have happened if the surgeon had used steel wire to close the wound. At the panel proceedings, he realized from expert testimony that steel wire wouldn't have changed things a bit. So he withdrew his complaint.

In another case, a G.P. was charged with having deserted an OB patient. She told a moving story of how the doctor had contracted to take her as a patient but had refused to attend her when she began to hemorrhage from a placenta previa. Said the woman: "He wouldn't even see me in the hospital after I had been admitted to the emergency room."

She seemed to have a strong case until the panel's investigations revealed these facts:

1. The patient had previously been aborted by her mother, a midwife. 2. The doctor had made no contract with the patient. 3. The doctor had no hospital staff privileges, since he usually did home deliveries. 4. He'd arranged for an obstetrician to take over the case when he discovered the patient was bleeding.

In brief, he was innocent of the allegations. Yet, without the panel, he might well have been haled into court.

Another patient was determined to sue her gynecologist. She claimed she'd suffered a pelvic abscess following a vaginal hysterectomy, and had then required a colostomy because of a bowel obstruction caused by the abscess. At the end of the panel proceedings, she was convinced she had no grounds for suit. So she shook hands with the doctor —and later made an appointment with him for continued care.

The panel has been even more successful in handling clear-cut nuisance cases. And the word

has gotten around. In at least four instances, a potential plaintiff has told his lawyer to drop the case rather than present it to the panel. Says Dr. Chesser:

"In any such instance, it's evident that the claimant has been withholding facts from his attorney. But he gets cold feet when it comes to trying to keep these facts from a panel with medical and legal knowledge and powers of investigation. Nuisance cases now seem to be a thing of the past in Pima County."

Naturally, no fair-minded group of doctors and lawyers would reject all malpractice claims presented to it. In one case, it was clear from the outset that a malpractice claim was justified, and it never went beyond preliminary hearings. The claim, involving a death caused by a biopsy during a bronchoscopy, was quickly settled by the insurance company to the satisfaction of both sides.

The panel has asked every attorney who has appeared before it to give his frank opinion of the program. So far, all comments have been favorable—even from the men who have had the rug pulled out from under their clients' cases.

The doctors in the community are enthusiastic, of course. Says one Tucson surgeon: "We've got something really good here. We're receiving inquiries on it from all over the country. I'll be surprised if lots of other places don't soon follow our lead." END

The Inquiring Mind

A patient of mine with a collapsed lung was placed on oxygen. He lived on the second floor of a tenement. The stairway was narrow and steep. When I visited him after the oxygen tank had served its purpose and had been removed, his wife remarked: "The men had quite a time getting the tank up the stairway. It was much easier taking the tank down."

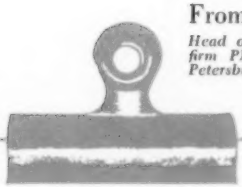
Then she added thoughtfully: "But of course, by then a lot of the oxygen had been used up, and the tank was almost empty."

—PAUL SLAVIN, M.D.

OFFICE MANAGEMENT MEMO

From J. Hugh Clissold

Head of the professional management firm PM of Florida West Coast, St. Petersburg, Fla.



Reminders That Pay Off

For years I've noticed that some physicians are liked by their patients much more than others are. Something they do apparently inspires genuine affection. Naturally, I've tried to spot the magic something. And it seems significant to me that the doctor who talks about the things his patient is interested in nearly always gets a high score in patient-affection.

Plenty of doctors who appreciate this still don't capitalize on it. Here's how you can:

Ask your secretary and nurse to find out *early* what Mr. Babbitt or Mrs. Doud is interested in. Make it your own first order of business, too. Whatever you find out, write it right on the patient's history sheet. Underline it so that every time you pick up the record your eye will be caught by the personal reminders—be they "stained glass," "Uncle Joe's airplane," "P.T.A. President," or whatever.

Make this a part of your regular routine, and you'll never be a bore to your patients. A bore, remember, is a man who talks to you about what *he* likes. END

What Makes a Partnership Click?

This survey suggests that you're likely to make a go of it if you and your partners are in the same field of practice, if you work together on a trial basis for several months, if you have a precise written agreement, if you share the workload as fully as possible, and if you have a well-developed sense of tolerance

By Hugh C. Sherwood

"A successful partnership depends on mutual confidence and respect. If two or more doctors have this, they don't need the restrictive clauses often included in partnership contracts. If they don't have it, no restriction will save their partnership."

So says a California surgeon who belongs to a thriving two-man partnership. Is he right?

Well, his opinion both jibes with and contradicts the views of other members of nearly 500 successful two- and three-man partnerships recently surveyed by MEDICAL ECONOMICS. None of the physicians surveyed denies the importance of mutual confidence. But they indicate that partners need more than that if they want lasting success.

What else does it take? The study reveals that experienced doctor-partners stress five basic recommendations. Here they are:

1. The partners should probably be in the same field of practice.

Of the several hundred surveyed two-man partnerships, only nine are made up of men in different fields. Of the more than 100 three-man partnerships, only nineteen include men in more than one field.

This doesn't necessarily mean that a G.P., say, and a surgeon are bound to be an unhappy combination. Most of the surveyed partnerships that contain men in different fields seem to be doing fine. But when two or more doctors are in the same field of practice, their partnership apparently has intrinsic advantages. For instance:

The doctors can give faster care. A Connecticut orthopedist reports that he once got an emergency call from his hospital when his office was crammed with patients. Fortunately, his orthopedist-partner was able to step in and take care of them while he went to the hospital. If he'd been practicing with a man in a very different specialty, of course, he'd have had to reschedule all the waiting patients.

They tend to stay on their toes

THIS ARTICLE *is the first of several based on a* MEDICAL ECONOMICS *study of some 500 two- and three-man medical partnerships.*

medically. Says a Pennsylvania G.P.: "When you have a partner, you get an extra perspective on difficult and/or serious illnesses. One of us often thinks of something the other forgot or overlooked. It makes practice more stimulating."

They're able to take more time off. The proof: In several surveyed G.P.-surgeon partnerships, the doctors don't swap night and week-end duty; each remains on call to his patients. As a result, say some of these men, they have little or no more free time than they would in solo practice.

It's different with partners who are in the same field. Many of the respondents cite the joys of a full night's rest on alternate nights, of frequent carefree week-ends, and the like. And a number of them emphasize the cumulative effect of such rest periods. Says a California G.P.:

"I have twice gone on short vacations with two colleagues—one an OB/Gyn. man, the other a urologist—who are in solo practice. On both occasions, my friends have been nervous wrecks by the time we were ready to go. I, on the other hand, have been entirely relaxed."

2. The partners should have a fairly long trial run before formally joining forces.

Nearly two out of three of the successful partnerships studied by MEDICAL ECONOMICS began on a trial basis. The comments of a number of the respondents indicate that a trial period is very nearly a must. It may last for three, six, or nine months. In most cases, though, the doctors say they waited a full year.

A trial period that lasts considerably more than a year can evidently cause tension. Two New Jersey specialists report that they let three years elapse before cementing their agreement—but that they wouldn't do it again.

They're Sprouting In the Cities

About two in five of the 500-odd partnerships surveyed by MEDICAL ECONOMICS are in big metropolises. The next largest number are located in various smaller cities; the third largest in the suburbs. Only one in twelve is in a rural area.

Although the partnership is now functioning well, it apparently wasn't easy for the two men to get used to a binding relationship after three long years of an informal association.

In most of the surveyed partnerships, one physician (or two in the three-man offices) worked as a salaried assistant during the trial period. This seems a common experience regardless of whether the partners are now equals or whether one is senior, the others juniors.

A few of the respondents say they didn't need a prolonged trial run. Reason: They'd interned or taken their residencies together; or they'd been regularly covering for each other on week-ends and vacations; or one had leased the practice while the other was in military service.

Some of these men have never actually bothered to build fully formed partnerships. Explains one such doctor:

"Each of us has his own patients. We share expenses. All money goes into a general fund; after expenses have been paid, each of us is paid a salary on the basis of the money collected for him. We each own an equal share of the equipment. We exchange calls every other night and week-end. We cover for each other during vacation periods. But we have no written agreement. We're together but apart. We feel free this way, and we believe it works much better for the two of us than a more formal arrangement would."

But an overwhelming majority of the respondents prefer a formal arrangement preceded by a trial run.

Even a try-out doesn't necessarily assure the success of a partnership, of course. A few of the doctor-partners queried by this magazine admit they're not happy in their current arrangement. Comments one such man

Partners' Age Differences

In nearly half the surveyed partnerships, the age difference between the physicians is more than ten years. In somewhat more than one-quarter, the age difference is between five and ten years. In less than one-quarter, it's less than five years.

—a Michigan urologist who's breaking up his combined practice:

"I'd recommend that any person who contemplates partnership practice avail himself of professional counsel. Just reading about it isn't enough. Perhaps professional counsel would have advised us *not* to go into partnership. In the future, I'd like to find a person in the same specialty to share a waiting room with . . . No more of this 'Gold Dust twins' stuff for me!"

3. The doctors should draw up precise written agreements to govern their partnership.

Whether they had trial periods or moved directly into combined practice, nearly two out of three successful partnerships started out with a written agreement. And where the agreements were originally oral, [*More on 138*]

Roll Dem Bones!

As a senior medical student, I received an unforgettable lesson in quick-wittedness from an interne.

He was on duty in the emergency room one evening when a very prominent young woman was rushed in with a chicken bone stuck in her throat. Noting her acute distress, he hastily bundled her into an old wooden wheel chair and headed her for the O.R.

The emergency room was attached to the main part of the hospital by a long, sloping, tunnel-like corridor with large steam radiators along each wall. The young interne started pushing his patient down this corridor at a very fast pace, when to his horror the wheel chair got away from him and careered on ahead. Before he could catch up, it had crashed into one of the radiators with such a jolt that the chicken bone was dislodged and landed in the patient's lap.

The interne rushed up and took in the situation at a glance. "Well!" he exclaimed. "You're one of the lucky ones, Ma'am. We usually have to take this run three or four times before the bone comes out!" —D. M. STILLWELL, M.D.

Don't Let Those New-Car Price TAGS Fool You!

The law requiring new cars to be tagged with the manufacturer's suggested retail price protects you from some of the dealer's old dodges. But it still leaves him room for outsize profits—as this doctor learned too late

By Robert L. Brenner

A Newark, N. J., doctor whom I know thought he got a very good deal on the new car he bought last month. Dr. Rodney Silvers, as I'll call him, felt he was given a fair allowance on the 1956 Chrysler he traded in. And he was positive the dealer wasn't overcharging him for the new Pontiac he bought.

Why positive? Because the manufacturer's suggested retail price was tagged on the Pontiac's windshield, as the law now requires. The tag also showed the shipping charge and the price of most of the accessories and "extras" Dr. Silvers wanted—all of them items that unscrupulous dealers used to make exorbitant profits before the new-car-tag law was passed.

Was Dr. Silvers' faith in that price tag justified? He now knows it wasn't. He realizes that he actually paid about $250

more than he needed to for his new Pontiac—and not because he was cheated, but because he assumed it's no longer necessary to bargain when buying a new car.

To understand where the doctor went wrong, let's review his transaction with the dealer. Then we'll see just where he "lost" the $250.

"Your Chrysler's worth $1,270," the dealer said, pointing to the list price in his used-car guide. "But since your car is in tip-top shape, I'll allow you $1,350."

Next they looked over the new Pontiacs. The tag on the model Dr. Silvers liked showed a total suggested retail price of $3,819.89. (What this included is shown on the opposite page.)

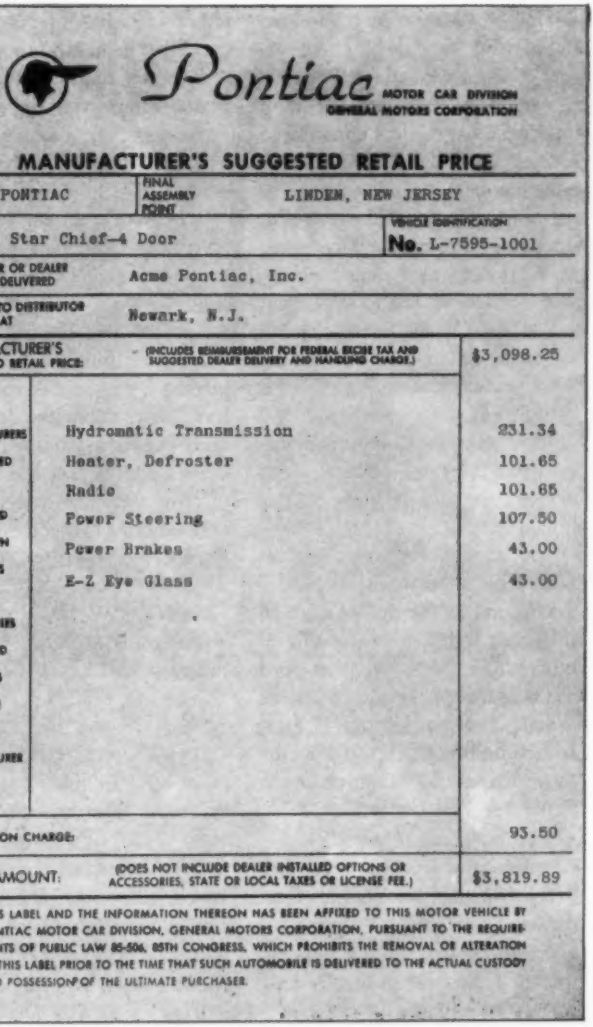
The dealer didn't ask Dr. Silvers to pay the full $3,098.25 base retail price. "That's the *maximum* I can charge under the new law," he explained. "I'd like to sell you cars in the future, too. So I'll cut $100 off it. I'm always willing to shave my profit to make a new customer . . . Now, would you like any extra accessories that aren't already on the car?"

Dr. Silvers decided to get white-wall tires, back-up lights, and plastic seat covers. And since house calls often take him out in filthy weather, he had windshield washers and body undercoating put on, too. The dealer's charge for each of these (including installation fees): white walls, $55; back-up lights, $20.50; seat covers, $40; windshield washers, $42.90; undercoating, $55.

Thus the car's total price went up to $3,933.29—minus the $1,350 trade-in allowance. So Dr. Silvers wrote a check for $2,583.29 and felt satisfied that the new tag law had taken the horse trading out of buying a new car.

The dealer was even more satisfied: The doctor's confidence in the new-car tag had given him a perfectly honest $250 that he hadn't really hoped to get. Here are the items Dr. Silvers had lost

TYPICAL NEW-CAR PRICE TAG *looks like this. Price breakdown shows what Dr. Silvers paid for "extras" that came with the car. See text for details.*



Pontiac MOTOR CAR DIVISION
GENERAL MOTORS CORPORATION

MANUFACTURER'S SUGGESTED RETAIL PRICE

PONTIAC	FINAL ASSEMBLY POINT	LINDEN, NEW JERSEY
MODEL Star Chief—4 Door		VEHICLE IDENTIFICATION No. L-7595-1001
DISTRIBUTOR OR DEALER TO WHOM DELIVERED	Acme Pontiac, Inc.	
DELIVERED TO DISTRIBUTOR OR DEALER AT	Newark, N.J.	

MANUFACTURER'S SUGGESTED RETAIL PRICE:	(INCLUDES REIMBURSEMENT FOR FEDERAL EXCISE TAX AND SUGGESTED DEALER DELIVERY AND HANDLING CHARGE.)	$3,098.25
MANUFACTURERS SUGGESTED RETAIL DELIVERED PRICES ON OPTIONS AND ACCESSORIES INSTALLED ON THIS VEHICLE BY THE MANUFACTURER	Hydromatic Transmission	231.34
	Heater, Defroster	101.65
	Radio	101.65
	Power Steering	107.50
	Power Brakes	43.00
	E-Z Eye Glass	43.00
DESTINATION CHARGE:		93.50
TOTAL AMOUNT:	(DOES NOT INCLUDE DEALER INSTALLED OPTIONS OR ACCESSORIES, STATE OR LOCAL TAXES OR LICENSE FEE.)	$3,819.89

THIS LABEL AND THE INFORMATION THEREON HAS BEEN AFFIXED TO THIS MOTOR VEHICLE BY PONTIAC MOTOR CAR DIVISION, GENERAL MOTORS CORPORATION, PURSUANT TO THE REQUIREMENTS OF PUBLIC LAW 85-506, 85TH CONGRESS, WHICH PROHIBITS THE REMOVAL OR ALTERATION OF THIS LABEL PRIOR TO THE TIME THAT SUCH AUTOMOBILE IS DELIVERED TO THE ACTUAL CUSTODY AND POSSESSION OF THE ULTIMATE PURCHASER.

money on because of his failure to bargain:

Trade-in allowance: Because the new tag law puts a ceiling only on what dealers can charge for *new* cars, the trade-in allowance has become a key bargaining point. The $1,270 figure that the dealer quoted Dr. Silvers for his Chrysler was the car's *wholesale* value. If the doctor had asked, he'd have found its *retail* value listed at $1,650—which left the dealer a potential $380 profit. The dealer dropped $80 of this. But in similar transactions he has been willing to cut another $100 when the deal has depended on it.

The new car's price: The retail price on the new tags is a maximum, as the dealer said. In this case it left him a profit of more than $500. He dropped $100 of this profit without being asked; but he admits he has sometimes cut the retail price by as much as $200 in order to make a sale.

"Extras" not already on the car: Dr. Silvers lost at least $50 here. The new law sets no limit on what a dealer can charge for accessories that aren't factory-installed. So he can legally jack up the price of any other items—either outright, or by charging an excessive installation fee.

But the manufacturer's suggested retail price for each "extra"—whether factory-installed or not—*is* listed in the dealer's guide. If Dr. Silvers had asked to see the list, he'd have found that the prices the dealer quoted him topped the suggested total by some $70.

Even with the new tag law, then, the thing that counts in buying a new car is still what it has always been: the *cash difference* between what you get for your trade-in and the total you pay for the new model. Dr. Silvers would have got his new car for less money if he had insisted on a bigger allowance on his Chrysler; if he had talked the dealer into taking less profit on the new Pontiac; and if he had checked on how much the dealer was making on the "extras."

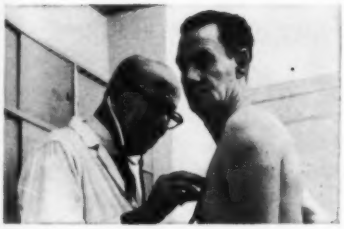
The lesson the doctor learned is an obvious one. The new-car price-tag law does protect you from some of the dodges unscrupulous dealers used to go in for. But it still leaves plenty of room for even an honest dealer to make a too-fat profit. Horse trading when you buy a new car still pays off. END

Pyribenzamine® EXPECTORANT breaks up cough

even persistent cough

Patient, factory worker, age 43, had suffered for months with persistent, dry cough, which he termed "smoker's hack."

Cough frequently interrupted his sleep, causing him to be nervous, irritable; his job efficiency was impaired.



Chest X-ray was negative and the plant physician prescribed PYRIBENZAMINE EXPECTORANT with Ephedrine. Patient noticed almost immediate relief—a week later felt "considerably better."

Pyribenzamine Expectorant with Ephedrine provides a unique combination of antitussive agents, which work three ways at once to break up the persistent cough: *Pyribenzamine* relieves histamine-induced congestion throughout the respiratory tract; *ephedrine* relaxes the bronchioles and makes breathing easier; *ammonium chloride* liquefies mucus, relieving dry cough and promoting productive expectoration.

Supplied: Pyribenzamine *Expectorant with Ephedrine,* containing 30 mg. Pyribenzamine citrate (equivalent to 20 mg. Pyribenzamine hydrochloride), 10 mg. ephedrine sulfate and 80 mg. ammonium chloride per 4-ml. teaspoon.

Also available: Pyribenzamine *Expectorant with Codeine and Ephedrine,* same formula as above with the addition of 8 mg. codeine phosphate per 4-ml. teaspoon (exempt narcotic).

Pyribenzamine® citrate (tripelennamine citrate CIBA)

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CIBA
SUMMIT, N. J.

WHAT DOCTORS DO ABOUT CHRISTMAS

Here's a report on the practice-connected presents they give and get, the number of cards they send to patients and colleagues, the number of bills they cancel at Christmas

By William N. Jeffers

This Christmas, two out of three doctors can expect a couple of gifts from colleagues and six or seven from patients. The third man, poor chap, won't get a thing (except, of course, from loving relatives and friends).

But then, maybe he isn't *giving* any practice-connected presents. Two out of five doctors aren't.

These holly-wreathed assumptions are based on last year's yuletide experiences of U. S. physicians, as indicated by a MEDICAL ECONOMICS spot-check. For some more of the same, read on. (If you'd rather be surprised on Christmas Day, hold this article till next Friday. Meanwhile, a Merry Christmas to you!)

Assuming you're among the fortunate men who do get prac-

THE HEART DISEASE PATIENT NEEDS RELIEF FROM EMOTIONAL STRESS

ANXIETY INTENSIFIES the physical disorder in heart disease. "The prognosis depends largely on the ability of the physician to control the anxiety factor, as well as the somatic disease."
(Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Cardiol. 1:395, March 1958.)

TRANQUILIZATION WITH MILTOWN enhances recovery from acute cardiac episodes and makes patients more amenable to necessary limitations of activities.
(Waldman, S. and Pelner, L.: Management of anxiety associated with heart disease. Am. Pract. & Digest Treat. 8:1075, July 1957.)

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Available in 400 mg. scored and 200 mg. sugar-coated tablets. Also available as MEPROSPAN® (200 mg. meprobamate *continuous release* capsules). In combination with a nitrate, for angina pectoris: MILTRATE®—(Miltown 200 mg. + PETN 10 mg.). ®TRADE-MARK

Miltown causes no adverse effects on heart rate, blood pressure, respiration or other autonomic functions.

WALLACE LABORATORIES, *New Brunswick, N. J.*

tice-connected gifts, what are they likely to be? Chances are, other doctors are sending you food or whisky. The survey reveals that one-third of last year's physician-recipients drew down edible bounty, including turkeys, baskets of fruit, hams, and exotic delicatessen. Roughly one-fifth got potable presents, including whisky and . . . well, whisky.

The next most popular present for one doctor to send another seems to be a gift certificate. One in ten got such a certificate from at least one colleague. And one in fifteen was given a medical book or instrument.

Half the doctor-Santa Clauses apparently shop for such items on their own. Wives or other family members handle the job for most of the rest, with an office aide doing it for one in twenty.

As to the kind of presents you can expect from your *patients*, this magazine has found them too general to classify. Let's say simply that the 1957 crop of patients' gifts ranged from ant farms to zinnias.

Now to draw back from you as an individual and peer at a

"To be blunt, Mr. Cutler, you've had it."

specifically designed to meet
the metabolic demands of convalescents
and patients on long-term therapy

new NOVO-BASIC

Squibb High Potency B-Complex with C for Maintenance

Each capsule-shaped tablet of NOVO-BASIC supplies:

Ascorbic Acid	150 mg.
Thiamine Mononitrate	5 mg.
Riboflavin	5 mg.
Niacinamide	50 mg.
Pyridoxine Hydrochloride	1 mg.
Calcium Pantothenate	10 mg.
Vitamin B_{12} Activity Concentrate	2 mcg.
Folic Acid	0.15 mg.

Dosage: One or more tablets of NOVO-BASIC daily as indicated.
Supply: Bottles of 60 and 180 capsule-shaped tablets.

NOVO-BASIC is designed to meet the *daily* metabolic demands of convalescents and those on long-term therapy for *adequate* supplies of B and C vitamins. These water-soluble vitamins are *continuously being excreted* and *must continuously be replaced*. NOVO-BASIC is also indicated in patients receiving prolonged diuretic therapy where vitamin loss can be excessive.

Prescribing NOVO-BASIC is an *effective* and *convenient* means of assuring that your patient gets these highly important vitamins daily—and in the quantities he needs. And with NOVO-BASIC your patient gets only *dietary* quantities of folic acid.

SQUIBB *Squibb Quality—the Priceless Ingredient*

'NOVO-BASIC' is a Squibb trademark.

picture of the profession in general, as it's apt to be shaping up right now:

When doctor gives doctor a Christmas gift, there's usually a special relationship between them, the survey indicates. Slightly over half the recipients of yuletide loot from colleagues are likely to be men who've treated the giver's family; about one in twelve is a locum tenens.

Thanks for Referrals

Surprisingly, the Westphalian ham or Old Grand-Dad seldom comes as a thank-you Christmas gift for referrals. Only one man in thirty says he acknowledges referrals by means of yuletide presents. And as small a minority exchange presents merely because they're neighbors.

What about Christmas cards? Four out of five respondents say they send them—to an average of twenty-eight colleagues. One in four mails greetings to doctors to whom he sends referrals; but only one in fifteen mails them to doctors from whom he *gets* referrals.

Nearly everybody—twenty-four respondents out of every twenty-five—receives yule cards from his patients. Average haul: fifty or so. And two out of three doctors mail them to patients. Average list: 135 names. Relatively few lists include all patients, though. (A Tennessee man says he restricts his Christmas card list to babies.)

The True Santas

But some of you are really playing Santa Claus to a few of your patients by canceling their bills. One in seven of the surveyed doctors did so last year—$250 worth, on the average. (Comments an Oregon practitioner: "But I never make anything special of it at Christmas. Hell, I cancel bills all year round.") The largest reported total gift of this sort: $900, from an Ohio man.

Why They Cancel

The usual reason for cancellation is that the doctor knows the patient has been having hard luck. One in ten respondents says he cancels only bills that he deems uncollectible anyhow. And a Washington, D. C., man reports that true generosity can turn red ink to gold: "Sometimes, along with return greetings, they send payment in full for the bill I've canceled."

More▶

Finally, what sort of seasonal decorations are you putting up in your office this year? If you follow last year's pattern, about half of you probably aren't decking your halls at all. The rest have hung a wreath on the door, or have stuck a few holly or pine sprigs behind the reception-room picture.

The survey suggests that very few American physicians do much more. ("I used to have a tree," reports an Iowa man. "But now we're too cramped for space.") A couple of reported exceptions:

A Minnesota M.D. says he usually installs a Nativity scene on his office lawn; it features four Christmas trees, a crib, and 125 colored light bulbs. And a Vermont doctor paints Santa and reindeer on his waiting-room windows.

So it seems that in decoration, as in other aspects of Christmas observance in the office, the typical doctor is restrained. As for New Year's Eve—well, MEDICAL ECONOMICS hasn't surveyed *that* subject. Anyhow, here's wishing you a happy (and not too restrained) New Year. END

Lecture With Zip

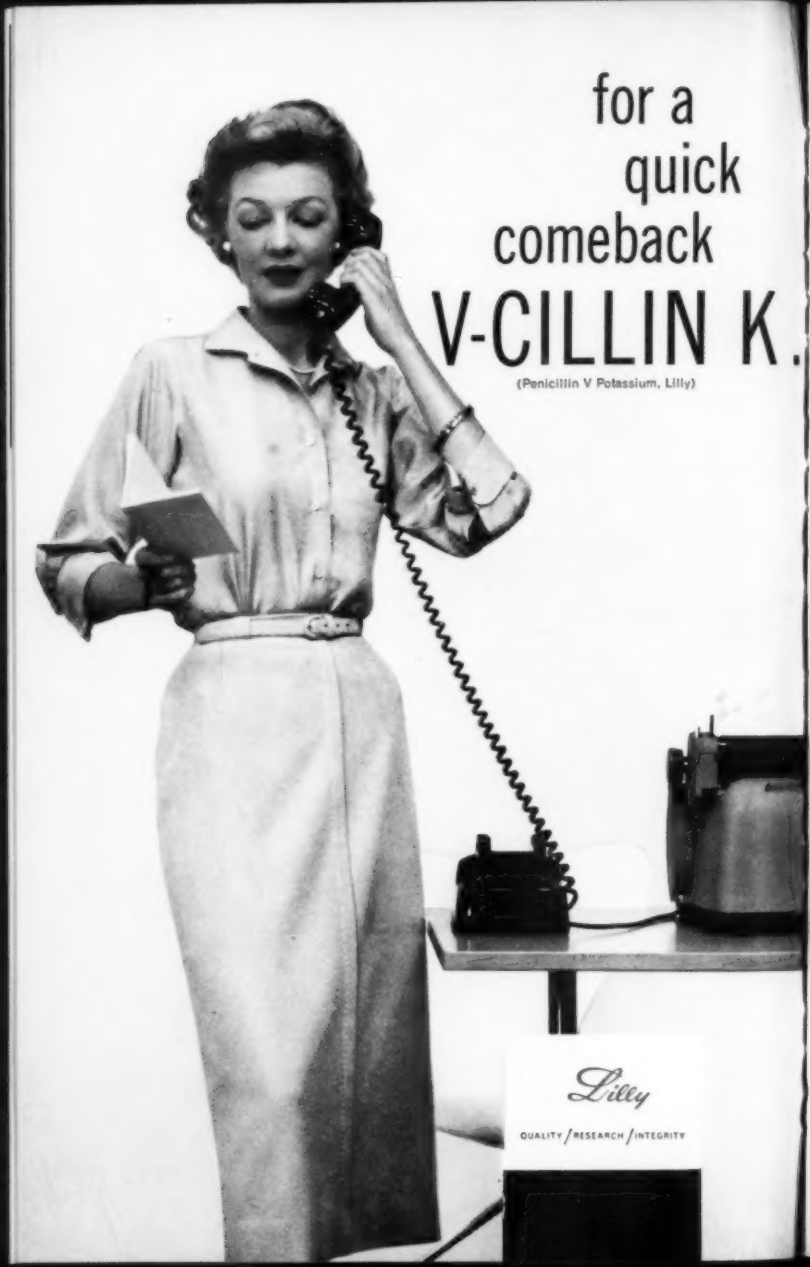
Some years ago when I was a P.G. student, a brilliant research man lectured the class. He looked like the proverbial absent-minded professor, his clothing wrinkled and unkempt. At one point, he stopped pacing back and forth before us and perched on the corner of a table. To the intense but silent amusement of the class, his trousers were unzipped.

Well, I was recently addressing a group of students myself and, to liven things up, I told that little story. It was greeted with an explosion of laughter, and I congratulated myself that I'd told a pretty funny anecdote.

I did, that is, until I went to the washroom after the class. There I discovered that all the time I'd been speaking, my own pants had been completely unzipped.

—GEORGE J. ORLANSKY, M.D.


FOR A
QUICK
COMEBACK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higher blood levels than with any other penicillin given orally. Bactericidal concentrations in tissues are assured. Infections resolve rapidly.

Dosage: 125 or 250 mg. three times daily.

Supplied: As scored tablets of 125 and 250 mg. (200,000 and 400,000 units).

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A unique taste treat your young patients will enjoy. The Lilly Junior Taste-Test Panel endorses this product with the highest appeal rating ever given a liquid preparation.

Supplied: In bottles of 40 and 80 cc. Each 5-cc. teaspoonful provides 125 mg. (200,000 units) of 'V-Cillin K.'

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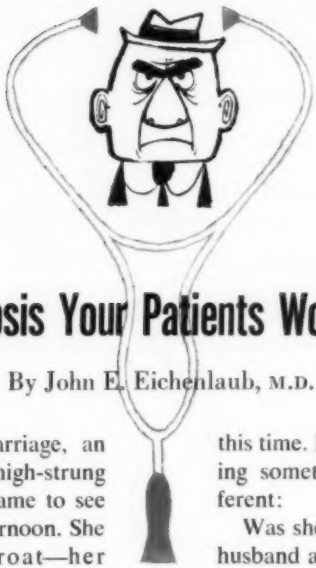
How do you tell a patient his ailment's rooted in his own emotions? Will he storm off to someone 'more understanding'? Not if you use the right words. They can put across what this doctor calls



The Diagnosis Your Patients Won't Believe

By John E. Eichenlaub, M.D.

A cousin by marriage, an attractive but high-strung young woman, came to see me the other afternoon. She had a sore throat—her fourth of the season. My examination revealed about what I expected: tissues only slightly inflamed, temperature about normal. Yet the patient was in misery.

Probably she was wondering what new medicine I'd prescribe this time. But *I* was wondering something entirely different:

Was she feuding with her husband again?

Still, I hesitated to mention anything so personal—even though I felt sure it was contributing to her ailment. That's a problem I seem to be facing more and more often in my practice. How can I suggest there may be psychic factors in

an illness without alienating the patient?

"You're damned if you do and damned if you don't," as one of my colleagues puts it. "If you don't tell your patient when you suspect there's an emotional reason for his trouble, you're not giving him the best treatment you know. If you do discuss emotions, he may be so upset he'll look for a doctor who's wise enough to keep his mouth shut."

Yes, it's a ticklish situation. But I've learned that there *are* ways to handle it. For one thing, I know that you can't usually help an emotionally upset patient by jumping right into a discussion of his emotions. He feels —and is—physically ill. That's why he's consulting a doctor. So I talk about first things first.

Only after I've shown I'm a-

"Now, when they ask me, I just tell 'em I'm a general specialist."

SPEED

PATIENT RECOVERY...

HELP MEET INCREASED

NUTRITIONAL DEMANDS

NEW MI-CEBRIN T

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VITAMIN-MINERAL

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Each Tablet Mi-Cebrin T provides:

Thiamine Mononitrate (B_1)	15	mg.
Riboflavin (B_2)	10	mg.
Pyridoxine Hydrochloride (B_6)	2	mg.
Pantothenic Acid (as Calcium Pantothenate, Racemic)	10	mg.
Nicotinamide	100	mg.
Vitamin B_{12} (Activity Equivalent) plus sufficient Intrinsic Factor Concentrate to produce activity equivalent to that of 1/2 U.S.P. APA unit (oral)*	7.5	mcg.
Folic Acid	0.2	mg.
Ascorbic Acid (as Sodium Ascorbate) (C)	150	mg.
Alphatocopherol (as Alphatocopheryl Succinate) (E)	5	mg.
Vitamin A Synthetic (25,000 units)	7.5	mg.
Vitamin D Synthetic (1,000 units)	25	mcg.

Contains also	**approximately**	
Iron (as Ferrous Sulfate)	10	mg.
Copper (as the Sulfate)	1	mg.
Iodine (as Potassium Iodide)	0.15	mg.
Cobalt (as the Sulfate)	0.1	mg.
Boron (as Boric Acid)	0.1	mg.
Manganese (as the Glycerophosphate)	1	mg.
Magnesium (as the Oxide)	5	mg.
Molybdenum (as Ammonium Molybdate)	0.2	mg.
Potassium (as the Chloride)	5	mg.
Zinc (as the Chloride)	1.5	mg.

Dosage: 1 tablet daily, or more as needed.

*B_{12} ABSORPTION BOOSTER

Intrinsic Factor Concentrate, Lilly, "boosts" the absorption of vitamin B_{12}, particularly in those elderly patients whose absorptive ability is impaired.[1]

1. Am. J. Clin. Nutrition, 5:451, 1957.

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ware of his physical discomfort am I ready for the next move. And as soon as I find the right opening, I say something like:

"Of course, as you know, an ailment like yours may stem from a person's emotions as well as from his body. It'll be a good idea, I expect, if we look for causes in both those areas."

Why So Early?

Are you wondering why I drop my hint of emotional origins before we've fully explored the patient's physical condition? My timing was suggested by an internist-friend. His theory: If you plant the idea of a possibly psychic origin early in the game, the patient is less likely to be startled by it later on.

Here's how the internist brought the subject up with one of his recent patients, a businessman who complained of recurrent spells of fatigue:

"Your weariness could be due to anemia or thyroid trouble. Or it could come from tension. Some people expect more from life than they're getting, and they feel let down. So let's make some tests to see whether your

. . . the nonbarbiturate with a four-hour action span, 'Valmid' helps your patients over the threshold of sleep, which, once induced, usually continues normally. Because 'Valmid' is a nonbarbiturate sedative with a very short action span, it permits a bright awakening without "hang-over" or other side-effects. 'Valmid' is notably safe, even in patients with liver or kidney damage, for whom barbiturates are contraindicated.

Prescribe 1 or 2 Tablets 'Valmid' to be taken about twenty minutes before bedtime.

*'Valmid' (Ethinamate, Lilly)

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weariness *is* entirely physical. Then we can go on from there."

Notice that this opening wedge serves two purposes. It invites the patient to think about his emotional problems without asking him to discuss them. And it's a trial balloon. It furnishes an advance clue to possible reaction to psychological talk later on.

But what about later on? Suppose the lab tests are negative and the doctor's pretty sure there's an emotional disturbance at the seat of the trouble?

I've found that when I feel compelled to bring up the subject, I often get one of several touchy responses. Here are a few of them, along with suggested techniques for coping with them:

"You don't believe I'm really ill at all!"

My answer to that one: "But of course I do. You've come to me because you *are* ill. Right now, though, let's try to find out what's causing your sickness."

"Do you mean I've dreamed up my trouble? It's just in my head?"

"In your head?" I may ask, in a surprised tone. "You've got a throat so sore you can hardly talk. Do you think *that's* in your head? Symptoms follow some physical or functional change. A person couldn't imagine an ailment like yours even if he wanted to."

A gastroenterologist I know tells me he's forever having to explain to his patients that indigestion caused by nerves is as real as any other kind. "We can actually see the changes inside a stomach like yours," he'll say. "If you get angry or upset, the lining of your stomach becomes raw. Emotion can make your stomach flush or turn pale, just the way your face does. Emotion can affect your stomach glands, just as it affects your sweat, your saliva, and your tear glands."

"Well, if I've let my worries make me sick, I guess I'm just a weakling."

Heard that one? It reflects the popular prejudice that mankind is divided into two parts: the worthy and the neurotic. Is it any wonder that many a patient thinks his courage is under attack when he's told his illness may be psychogenic? I often find a reminder from wartime handy in such cases.

More▶

"Put anybody in the world under enough stress," I may say, "and he'll have physical trouble. That's what they found during the last war. By the time an outfit had been in combat a little more than 300 days, every single one of the original members had to be shipped back to avoid a breakdown."

"But I don't see why you should think I'm under more strain than most people."

My usual comment here is that many of us labor under strains we don't recognize. "We can deal with strains we know about," I explain. "It's the ones we don't know about that make us break out in rashes. And you're no different from other people in that respect. I may be able to shrug off the kind of emotional problem that makes you physically ill. But I have no doubt *you* can shrug off some other kind that *I* can't take."

"But I'm really not very tense or nervous. You're wrong if you think I'm a worrier, Doctor."

I get this response commonly from the sort of person who's

proud of his ability to keep a firm grip on himself. Since I believe it's important not to *shock* him into better self-knowledge, I try not to contradict him. Instead, I say something like this:

"I'm sure you're right. Anyone can see you don't wear your feelings on your sleeve. But you do have emotions, just like all of us. And quiet, pent-up feelings may work on the body even more actively than violent ones do."

Sometimes it seems to me that a diagnosis of psychoneurosis is the one diagnosis most patients won't believe. The label "psycho" is like a red-hot brand to their ego. That's why I avoid the label and soften the blow in every way I can.

The doctors of some future generation may be able to talk to their patients about the psychic element as easily as they now talk about pneumonia. They may be able to say flatly: "You're neurotic." But today's patients aren't ready for such words. We have to prepare them for the truth by clearing away their misconceptions. Then they can usually face the facts. END

By Horace Cotton

How Well-Managed Is Your Practice?

This self-test—the ninth of a series—will help you handle three special fee problems

Let's say you've reviewed and revised your fees within the last twelve months. Let's say you're now charging what *you* think you're worth and what *you* think your patients will cheerfully pay. According to the previous self-test in this series, your fees are now right.

Can you still go wrong in applying them? Of course you can! I've seen doctors by the dozens undermine their perfectly proper fee schedules by:

¶ Failure to communicate cost-of-care information to patients at the right time.

¶ Failure to charge properly for multiple services

THE AUTHOR *heads his own professional management firm, which has headquarters in Southern Pines, N.C., and offices in major cities throughout that state.*

ACHROCIDIN*

TETRACYCLINE-ANTIHISTAMINE-ANALGESIC COMPOUND LEDERLE

A versatile, well-balanced formula for treating common upper respiratory infections, particularly during respiratory epidemics; when bacterial complications are observed or are likely; when patient's history is positive for recurrent otitic, pulmonary, nephritic, or rheumatic involvement.

CHECKS SYMPTOMS: Includes traditional components for rapid relief of the traditional nonspecific nasopharyngitis, symptoms of malaise, chilly sensations, inconstant low-grade fever, headache, muscular pain, pharyngeal and nasal discharge.

Available on prescription only.

Adult dosage for ACHROCIDIN Tablets and new caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

TABLETS *(sugar coated)*
Each Tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100.

SYRUP *(lemon-lime flavored)*
Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

Bottle of 4 oz.

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
*Reg. U. S. Pat. Off.

THE ORINASE* EPOCH

Freed from the encumbrances of needle syringe and sterilization, and freed from the tensions caused by worry about potential hypoglycemic reaction, the patient on Orinase can look forward to a more normal type of life in which his metabolic disorder is not complicated by the paraphernalia of injection.

For the newly discovered patient, the diagnosis of diabetes is no longer a commitment to a long sentence of injections. Families of diabetics can now assume a more normal way of life, unimpeded by social and economic disabilities and the personal demands of the metabolic invalid. This new era has opened for the majority of diabetics. Those most responsive have had onset of diabetes after 40 years of age and, if on insulin, generally require less than 40 units daily.

"Orinase-responsive" patients, as a group, usually enjoy a superior quality of control. With Orinase, the management of diabetes is smoother, associated with a feeling of greater stability and well-being, and free from the danger of hypoglycemic shock. Patients are more cooperative and can assume occupations from which hormonal therapy might disqualify them.

New diabetics are easier to indoctrinate and to manage. Mild diabetics, who either personally object to insulin or whose diabetes is so mild as to make one hesitate to add insulin to the regimen, are both excellent candidates for Orinase.

It has been shown that in the presence of a functional pancreas, Orinase effects the production and utilization of *native* insulin via *normal* channels. Its administration results in changes in fat and protein metabolism known to be the physiologic resultants of insulin activity. More recently, several investigations have demonstrated that the effects of Orinase upon hepatic glucose release are none other than those of endogenously produced or endoportally administered insulin. These observations have been followed by the further realization that the liver may play a primary physiologic role in the mechanisms of insulin action. Experience with Orinase suggests a classification of diabetics into two apparently distinct groups —Orinase-responsive or "Orinase-positive" diabetics, and "Orinase-negative" diabetics. It remains to be determined whether these will prove to be distinct clinical entities.

rendered during one office visit.

¶ Failure to charge properly when the patient has health insurance.

You can't really say you have a well-managed practice until you've checked yourself on these three points. Here are the questions that will help you do it. Check off your answers, then interpret them in the light of the commentary below:

1. What sort of fee discussion with patients takes place in your office?

Fees are discussed routinely before service . . . . . ☐
Fees are discussed only at patient's request . . . . ☐
Fees are discussed as little as possible . . . . . ☐

Most doctors tell me they talk fees only if the patient initiates the discussion. If you say the same, give yourself a black mark.

I can hear the G.P.s and internists saying: "If he thinks I'm going to discuss five bucks with everyone who comes to the office, he's crazy!" I'm not crazy. Here's how I explain the ABCs of fee discussion to such men:

A. The patient whom you are meeting for the first time wants to know what it will cost to have you take care of him. He frets about it until he gets an answer.

B. Therefore this cost-of-care information must be communicated to him at his first visit. For small services, it can be disclosed *after* the laying on of hands, when he's on the way out. For major services—a complete examination, a prolonged course of medical treatment, a surgical operation—it should be disclosed *before* said laying on of hands.

C. If you can talk money without embarrassment, by all means do so. If you can't, see that the front-office girl does it. But the talking must be done. Fee schedules posted in the reception room are no substitute.

The plain truth behind these ABCs is that *people keep bargains better than they pay bills.* They're more apt to come through with the green stuff if they agree to your fees beforehand than if they're surprised by your bills afterward.

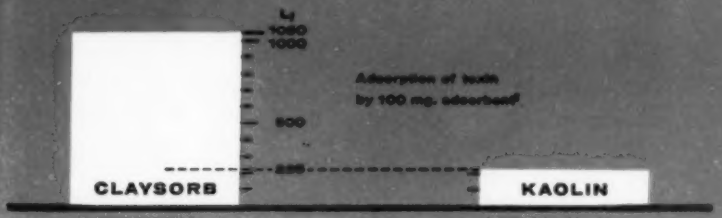
2. How do you set fees for two or more services rendered at the same visit?

Add 'em up and announce the result . . . . . ☐
Add 'em up, take fright, and announce a smaller result . . . . . ☐

The odds are better than fifty-

in diarrhea . . .

adsorptive power



CLAYSORB is 5 times as adsorptive as kaolin

When you prescribe POLYMAGMA or POLYMAGMA Plain to control diarrhea, you are prescribing adsorptive superiority. Both preparations contain Claysorb—a new intestinal adsorbent whose superiority over kaolin has been demonstrated in exhaustive studies.[1,2,3]

For *bacterial* diarrhea, POLYMAGMA is bactericidal to many intestinal pathogens. It is soothing and protective to the irritated mucosa. It aids in the restoration of normal intestinal function. Highly effective, highly palatable.

For *nonbacterial* diarrhea, POLYMAGMA Plain —same formula but without antibiotics.

1. Barr, M., and Arnista, E.S.: J. Am. Pharm. A. (Scient. Ed.) *46*:493 (Aug.) 1957. 2. Barr, M., and Arnista, E.S.: *Ibid.* *46*:486 (Aug.) 1957. 3. Barr, M.: *Ibid.* *46*:490 (Aug.) 1957.

Polymagma®

Dihydrostreptomycin Sulfate, Polymyxin B Sulfate, and Pectin with Claysorb* (Activated Attapulgite, Wyeth) in Alumina Gel

*Trademark

Wyeth® Philadelphia 1, Pa.

This advertisement conforms to the Code for Advertising of the Physicians' Council for Information on Child Health.

fifty that you checked the second box. If you did, you're one of a multitude. This is what a charge slip might look like if filled out *your* way:

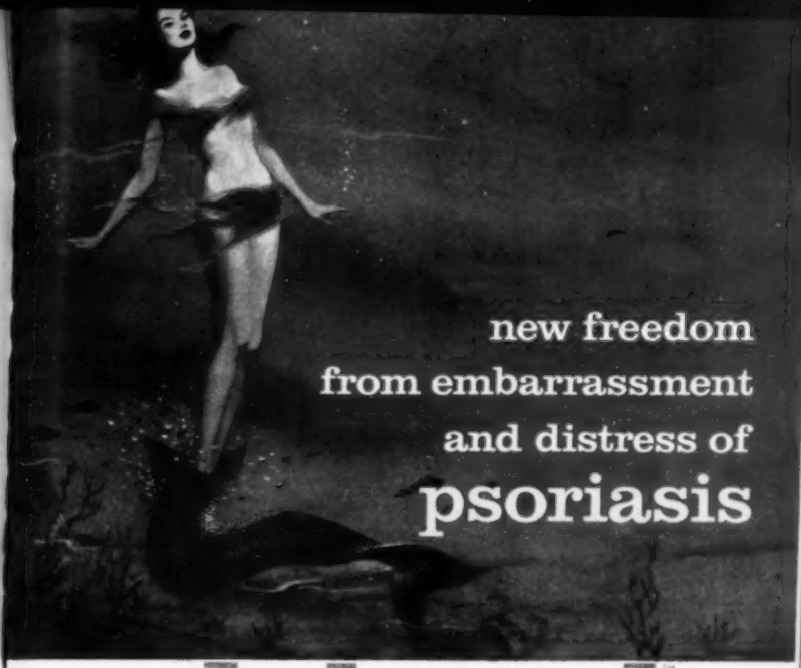
Office visit	$3
Urinalysis	1
Injection	2
Diathermy	3
Total	$9

My name for this is "telescoping." It costs thousands of medical men scads of money every day. They reason it out like this:

"Hmm, let's see: office visit three, urine one, shot two, heat three. Total: nine. Cripes, that looks like a lot. I spent only ten minutes with her myself. And that prescription I gave her will probably set her back eight or nine more. I'd better charge six."

Whereupon the physician writes off his own time and skill. He's content to collect for the use of his "facilities"—i.e., the nurse, the urine glass, the needle, and the cooker.

Take a tip from me, Doctor: Whatever else you do, be sure to collect the cheerful fee for *your own* professional service. You're not peddling lab work, shots,



alphosyl™

LOTION

A notable advance in topical therapy of psoriasis: Keratin-dispersing action;[1] stimulation of healing.

Successful results ranging to complete clearing obtained[2-5] in patients with: ■ scalp-to-toe psoriasis ■ psoriasis of many years' duration ■ psoriasis involving tender areas.

Treatment-fastness has not occurred

Safety: Avoids potential hazards of other therapies – mercury, arsenic, corticosteroids, x-rays.

A noteworthy advance cosmetically: Nongreasy, nonstaining; vanishes on application to the skin. May be used freely on the scalp.

Application: Rub thoroughly into lesions 2 to 4 times daily. In cases of long duration, initial response may take several weeks. Often, in obstinate cases, hot baths before applications hasten response. *Maintenance:* Apply 2 or 3 times weekly, or daily if necessary.

Formula: Allantoin 2% and special coal tar extract 5% in a lotion base.

Supplied: Bottles of 8 fl. oz.

(1) Flesch, P.: Reported Conf. N. Y. Academy Sciences May 9, 1958 (In Press). (2) Bleiberg, J., and Saltzman, J. A.: Clin. Med. 5:485 (Apr.) 1958. (3) Bleiberg, J.: Reported Conf. N. Y. Academy Sciences May 9, 1958 (In Press). (4) Clyman, S. G.: Reported Conf. N. Y. Academy Sciences May 9, 1958 (In Press). (5) Samitz, M. H.: Reported Conf. N. Y. Academy Sciences May 9, 1958 (In Press).

R&C REED & CARNRICK / *Jersey City 6, N. J.*

and electricity. You're a *doctor*. Yet every time you telescope, *you're* the one who takes the cut. The "facilities" still sell at the standard price.

3. How do you charge patients who have medical-surgical insurance?

Charge more than your standard fees, since patients' share is small anyway . . . . . ☐

Stick to your standard fees . . . . . ☐

Take what the insurance company pays, even if it's less than your standard fees . . . . . ☐

If you checked the first box, Doctor, I'd like a word with you. Only this time I'm speaking with two voices: the voice of a management man and the voice of an insured patient.

As a management man, I'll tell you flatly that if Federal medicine ever fastens itself on the U.S.A., you will have helped lay the red carpet for it. The voluntary system of prepayment for medical care is this country's strongest bulwark against socialized medicine. Kill that system by gouging it, and you also kill private medicine as we know it today.

And as an insured patient, I'd like to ask you why I, the provident, thrifty breadwinner of my family, should pay you more than you ask from the improvident individual who carries no insurance and who probably won't pay you at all until you set the collection agency on his track. I'm giving it to you straight, Doctor. I've proved my willingness to pay you. If I wanted to sponge on you, I wouldn't have the insurance at all, would I?

So charge me your regular fee —the cheerful fee—for whatever you do for me. I'm glad to be able to pay it. But don't fine me 25 per cent extra for forking out the premiums that give me the ability to pay.

Oh, and Doctor: It cuts both ways. If my insurance doesn't provide enough to pay your regular charge, just ask me for the difference. I don't want favors; I just want to be treated the same way as others.

Maybe you think I'm not typical. Tell you what: Bring up this question at your next civic gathering or club meeting or cocktail party for non-doctors. You'll soon find out how typical I really am. END

When Callers Say 'It's an Emergency!'

Do you have a priority system for emergency cases? Does your aide recognize an emergency when she sees one? These simple tips may help

BY J. P. LEEDS

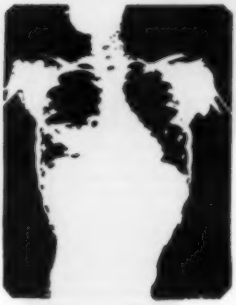
Some time ago, MEDICAL ECONOMICS printed a cartoon showing a battered, weakened patient barely able to crawl on all fours into the doctor's office. As he clutches at the receptionist's desk for support, the girl seated there looks up from a magazine she's reading and says with total lack of concern: "Have you an appointment?"

Physicians who were amused at that cartoon wouldn't chuckle if they thought it applied to their own offices. Yet in some cases it almost does. I've heard a couple of real-life stories lately about emergency patients who were forced to wait their turn. Why? Because the doctor's aide didn't recognize an emergency when she saw one.

Recognition should properly begin with the first phone call. It takes only two questions: "What seems to be troubling you, Mrs. Johnson?" and then "How long has it been troubling you?" (If the answer to the second of these two questions is "About four or five days," then even the patient may concede that it

NEW

realistic therapy in pneumonia



A 13-year-old girl with penicillin-resistant pneumonia received an initial dose of 1250 mg Madribon, followed by 625 mg daily. On the third day of Madribon treatment, the temperature returned to normal. X-rays showed marked improvement in the lung fields. She was discharged eight days later.[1]

A NEW BRIGHT SPOT IN ANTIBACTERIAL THERAPY

Madribon

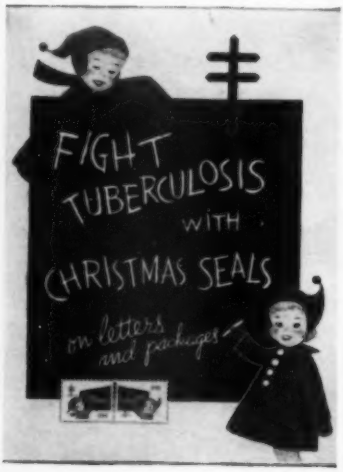
ROCHE

A completely new antibacterial... wide-spectrum activity... 24-hour action on a single, low dose[2,4]... less than 2% side effects in more than 7000 cases.

"The use of Madribon was very simple and there were no side effects or toxic reactions."[3]

MADRIBON T.M. —brand of 2,4-dimethoxy-6-sulfanilamido-1,3-diazine ROCHE—Reg. U.S. Pat. Off.

ROCHE LABORATORIES • *Division of Hoffmann-La Roche Inc* • *Nutley 10* • *N. J.*



isn't really a true emergency.)

Recognition in the waiting room is also important—and not only recognition by the receptionist. Other patients whose appointments are delayed need to know why.

Some doctors give postoperative patients red priority cards to display. As a rule, though, personal explanations to the other patients in the waiting room are better.

Your aide can handle such explanations quite simply—once she's reminded to make them part of her routine. END

Amusing . . .
Amazing . . .
Embarrassing . . .

No doubt one of these adjectives describes some incident that has occurred in the course of your practice.

Why not share the story with your colleagues?

If it's accepted for publication, you'll receive $25-$40 for it.

Contributions must be unpublished. They cannot be either acknowledged or returned. Those not accepted within ninety days may be considered rejected.

Address: Anecdote Editor, MEDICAL ECONOMICS, Oradell, N. J.

NEW

realistic therapy in otitis media

The new antibacterial Madribon has achieved therapeutic success in 65 of 72 patients with otitis media.[1] Madribon proves highly effective against many gram-positive and gram-negative pathogens, including staphylococci, streptococci, pneumococci, E. coli, klebsiella and listeria.

A NEW BRIGHT SPOT IN ANTIBACTERIAL THERAPY

Madribon

A completely new antibacterial... wide-spectrum activity... 24-hour action on a single, low dose[2,4]... less than 2% side effects in more than 7000 cases.

"The use of Madribon was very simple and there were no side effects or toxic reactions."[3]

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How to Beat The Secretary Shortage

Fringe benefits are the answer. Here are four that pay off in medical offices

BY ALTON S. COLE

Perhaps you haven't noticed, but the secretary shortage is becoming acute. Remember the low birth rate of the depression years? Well, it's just now having its full effect. Today there are a million fewer young women between 20 and 25 than there were a decade ago. And more of them are getting married, having children, giving up office work.

What does this mean to you as an employer? Well, it means that you've got to expect stiffer competition in bidding for scarce secretarial talent. Already, in some large cities, beginning secretaries are getting $75 a week. They're also being offered certain fringe benefits (e.g., pension plans) that you can't hope to duplicate.

If you've got a good girl now, how can you keep her? I'd suggest that you consider offering some fringe benefits of your own. The following, for example, have worked well in medical offices:

Overtime pay: A Detroit physician discovered that his employes were most likely to grumble about extra night work. He now pays time-and-a-quarter for authorized evening hours; and the grumbling has ceased. Quite a few other medical offices use this same formula.

Sick leave with pay: A Cin-

NEW

realistic therapy in respiratory infections

A completely new antibacterial

Low dose, 24-hour action

Safer

References: 1. E. H. Townsend and A. Borgstedt, Paper read at the Sixth Annual Symposium on Antibiotics, Washington, D.C., October 15-17, 1958.

2. S. Ross, J. R. Puig and E. A. Zaremba, Paper read at the Sixth Annual Symposium on Antibiotics, Washington, D.C., October 15-17, 1958.

3. W. A. Leff, Paper read at the New Jersey Chapter of the American Federation for Clinical Research, East Orange, N. J., September 17, 1958.

4. W. P. Boger, Paper read at the Sixth Annual Symposium on Antibiotics, Washington, D.C., October 15-17, 1958.

A NEW BRIGHT SPOT IN ANTIBACTERIAL THERAPY

Madribon

ROCHE

DOSAGE		TABLETS		SUSPENSION (teasp.)	
		initially	q. 24 h.	initially	q. 24 h.
ADULTS:		2	1	4	2
CHILDREN:	20 lbs	½	¼	1	½
	40 lbs	1	½	2	1
	80 lbs	2	1	4	2

The above dosage should be doubled in severe infections requiring more intensive therapy. Continue therapy for 5 to 7 days, or until patient is asymptomatic for at least 48 hours.

Tablets, 0.5 Gm

Suspension, 0.25 Gm./teasp.

Caution: The usual precautions in sulfonamide therapy should be observed, including the maintenance of adequate fluid intake. If toxic reactions or blood dyscrasias occur, use of the drug should be discontinued. As is true of all sulfonamides, Madribon is probably contraindicated in premature infants.

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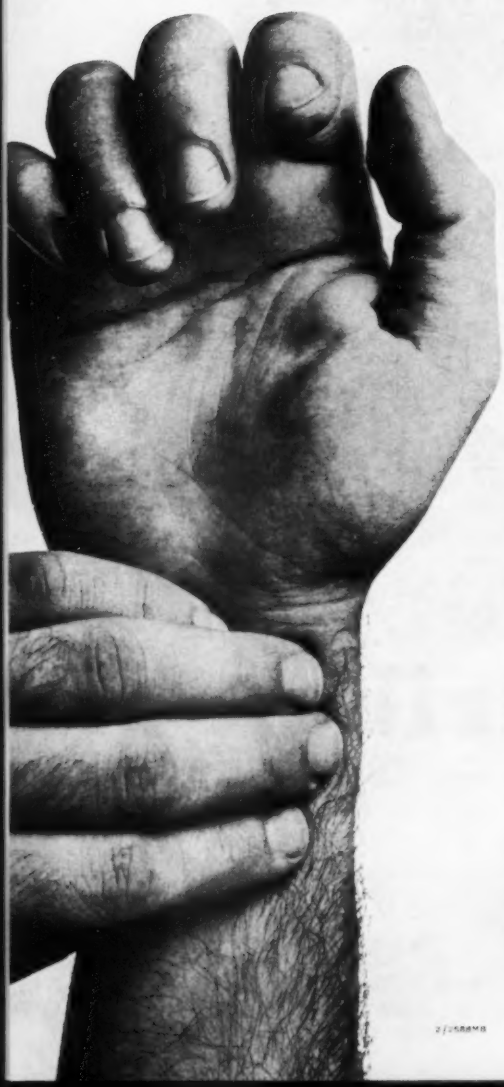


pulse rate up?

Serpasil slows heart rate in most cases of organic or functional tachycardia.

You'll find it especially valuable in cardiac patients whose conditions are aggravated by heart speed-up. Through a unique heart-slowing action, independent of its antihypertensive effect, Serpasil prolongs diastole and allows more time for the myocardium to rest. Blood flow and cardiac efficiency are thereby enhanced.

What's more, you can prescribe Serpasil with confidence. Therapy with Serpasil is virtually free of the dangers (heart block and cardiac arrest) heretofore encountered with heart-slowing drugs. Side effects are generally mild and can be overcome by adjusting dosage.

DOSAGE FOR TACHYCARDIA
Dose range is 0.1 to 0.5 mg. (two 0.25-mg. tablets) per day conveniently taken in a single dose. Rapid heart rate usually will be relieved within 1 to 2 weeks, at which time the daily dose should be reduced. Suppression of tachycardia often persists after therapy is stopped.

NOTE: In patients receiving digitalis or quinidine, Serpasil therapy should be initiated with especially careful observation. Serpasil is not recommended in cases of aortic insufficiency.

SUPPLIED: *Tablets*, 1 mg. (scored), 0.25 mg. (scored) and 0.1 mg. *Elixirs*, 1 mg. and 0.2 mg. Serpasil per 4-ml. teaspoon.

slow it down with

Serpasil®

(reserpine CIBA)

2/1558MB

CIBA SUMMIT, N. J.

cinnati doctor allows his aides two weeks' absence for illness during the year. (Beyond two weeks, their pay stops.) And for every unused day of sick leave, they get a half-day's additional vacation time. Thus there's some incentive for not missing much work.

Optional holidays: A Manhattan M.D. observes all legal holidays—and allows his aide five extra holidays besides. She can take these on Columbus Day, Armistice Day, the Friday after Thanksgiving, or "whenever mutually convenient." They're in addition to the usual vacation with pay.

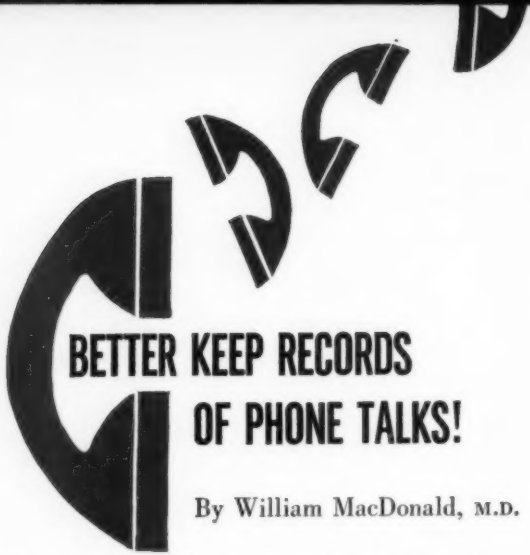
Year-end bonuses: Just before

Christmas, a Chicago practitioner pays two weeks' extra salary to aides who have been with him throughout the year. Just before the New Year, another Chicago physician pays his secretary 1 per cent of his gross earnings for the year. Such bonuses have a great stabilizing influence.

The greatest stabilizing influence, of course, is a respectable basic salary. Many doctors nowadays can compete with industry on this score. Others can at least come close enough so that special benefits will make up the difference.

Free medical care is one such benefit. (Even for major medical services, 75 per cent of doctors charge their aides nothing at all, according to a past MEDICAL ECONOMICS survey.) But free medical care, by itself, may no longer be enough of an inducement.

If that's getting to be the case in your area, better think about the fringe benefits mentioned here. They're tax-deductible and not too costly. In fact, they're just about the cheapest insurance you can buy against the secretary shortage. END



BETTER KEEP RECORDS OF PHONE TALKS!

By William MacDonald, M.D.

Rough notes jotted down on a specially designed pad can amount to good professional protection

A man phoned me recently to come and see his housemaid, who, believe it or not, had housemaid's knee. His closing remark was: "I'll take care of the bill."

Much later, when the time for payment came, he insisted that what he had said was: "I'll tell you where to send the bill."

That got me thinking. I decided it was time to protect myself by making some kind of record of every telephone conversation with or about a patient.

First I thought about installing an electrical recorder. But this didn't quite suit my purpose. For one thing, most good recorders are expensive. For another, you can never be sure whether a conversation is worth recording until it's well under way.

Instead, I had a pad of blanks printed. Each sheet is headed "Record of Phone Conversation" and carries my name and address, with blank spaces for date, hour, and name of caller. The rest of the sheet is divided by a vertical line. The left side is captioned "What I Said" and the right side is captioned "What

ever been on a "Washboiler Clambake"

If you like to have fun with food, try this recipe handed down from the American Indians to the first colonial settlers — and now popular throughout the country. Whether it's prepared on the beach, patio, in the backyard, or even in the kitchen, you'll have a bucket of fun.

Take an old-fashioned washboiler or its equivalent and place a rack in the bottom over an inch or so of water.

Place a layer of chowder clams on the rack.

Cover the clams with a layer of seaweed, salt hay, or romaine lettuce leaves.

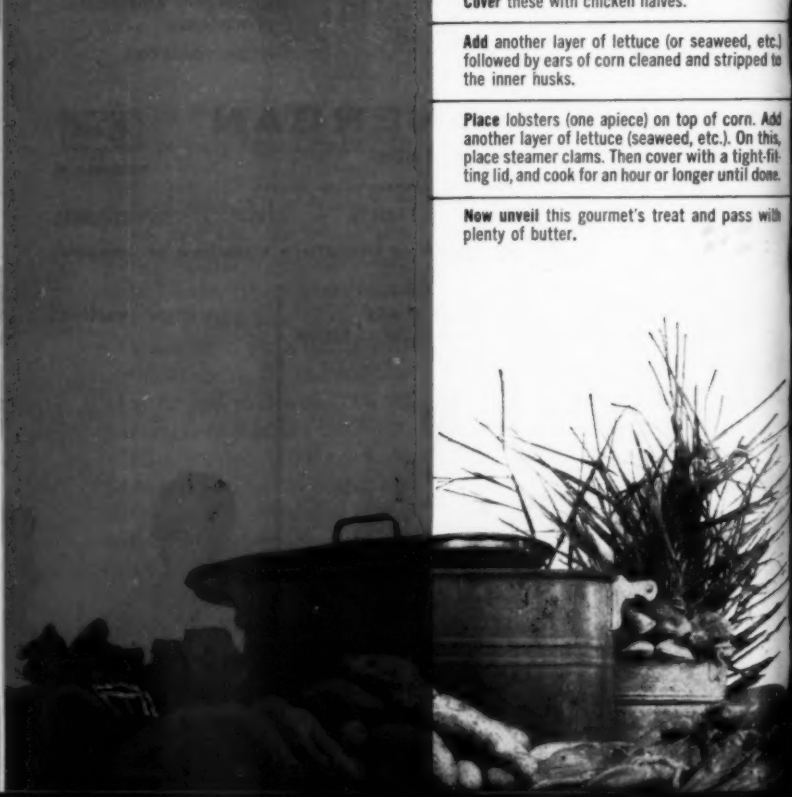
Next make a layer of white or sweet potatoes.

Cover these with chicken halves.

Add another layer of lettuce (or seaweed, etc.) followed by ears of corn cleaned and stripped to the inner husks.

Place lobsters (one apiece) on top of corn. Add another layer of lettuce (seaweed, etc.). On this, place steamer clams. Then cover with a tight-fitting lid, and cook for an hour or longer until done.

Now unveil this gourmet's treat and pass with plenty of butter.



Caller Said." A pad of these forms is always on duty at every telephone.

How They're Used

When it appears desirable to record the gist of a conversation (even after it has started), it's an easy matter to jot down the essential features. The page is then filed together with the patient's clinical record.

Now suppose that some minor misunderstanding develops as a result of a phone conversation. Next time the patient is in the office, I show him my notes. Since the record was obviously written during the conversation, the patient is likely to be impressed, not only with the true facts of the case but also with the thoroughness of the system I'm using.

A Timesaver, Too

Even more important, the written notes fill those gaps in a patient's record that always develop when only data from office and house visits are entered. Just before an appointment, I look over the patient's file—including the telephone notes. They refresh my memory and cause me to waste less time with the patient on ground that has already been covered. END

In potentially-serious infections...

*TRADEMARK, REG. U. S. PAT. OFF.

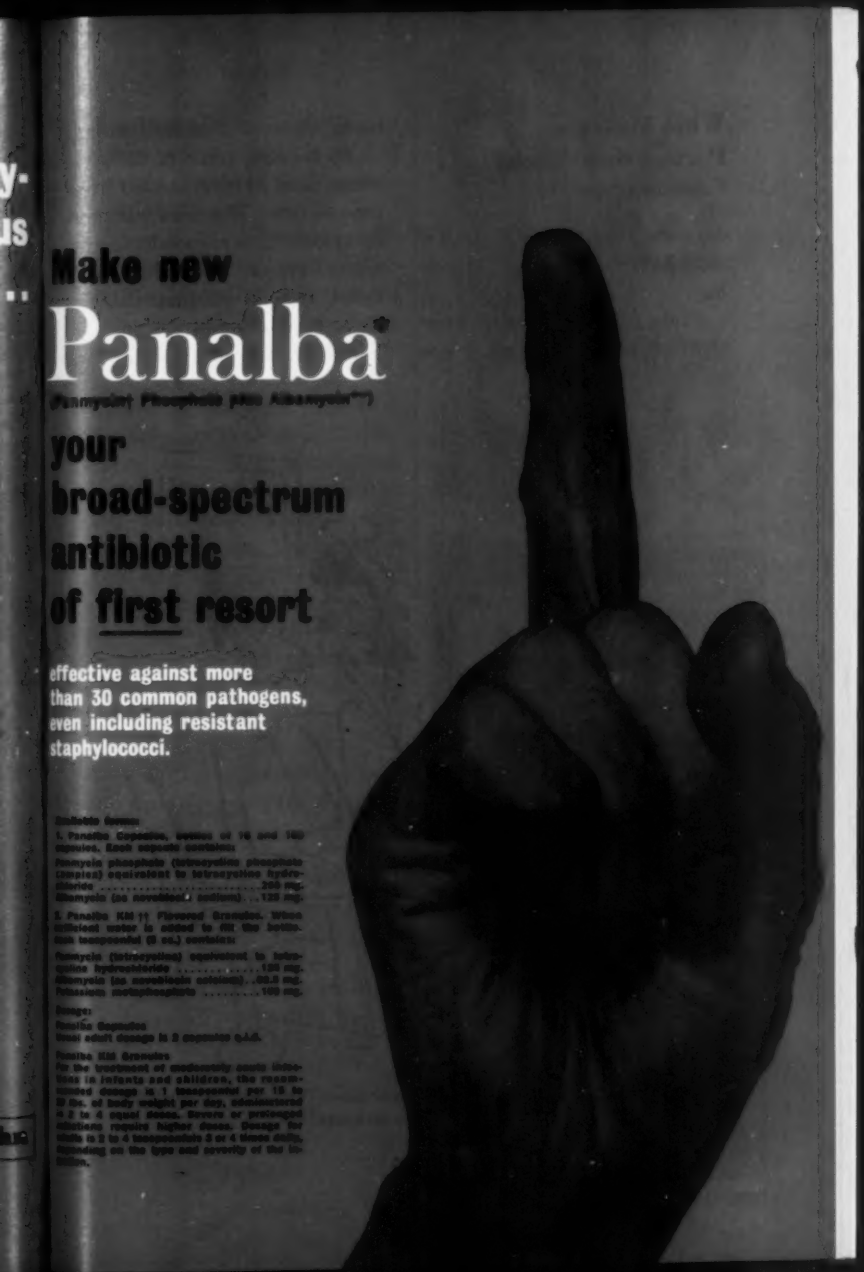
†TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF TETRACYCLINE

**TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF CRYSTALLINE POTASSIUM PENICILLIN G

††TRADEMARK

The Upjohn Company, Kalamazoo, Michigan

Upjohn


Make new
Panalba®
(Pamycin† Phosphate plus Albamycin††)
your
broad-spectrum
antibiotic
of first resort
effective against more
than 30 common pathogens,
even including resistant
staphylococci.

What Makes a Partnership Click?

Continued from 84

the survey indicates that most of them have since been put in writing.

Thus, only about one in every eight of the partnerships is now based on an oral understanding.

To be sure, some of the contracts need to be amended from time to time. The most common complaint from respondents who aren't entirely satisfied with theirs: It lacks adequate disability or dissolution provisions.

But the consensus of the doc-

"He has old magazines here on purpose: The new ones give all the latest treatments."

tor-partners is that *some* sort of written contract is a big step in the right direction. A few significant comments:

¶ From a California G.P.: "My senior partner seems reluctant to formalize the rules. I know our lack of written agreement will cause trouble some day."

¶ From a New Jersey internist: "I emphasize the absolute advisability of a carefully worked out, explicit, written contract as the best guarantee against subsequent disruptions. The next best guarantee is previous personal and professional acquaintance. We'd known each other well for eight years before undertaking our partnership. But we still needed that contract."

¶ From an Ohio G.P.: "We drew up our agreement slowly and carefully, starting in reverse

Most Partnerships Are Young

Only a dozen or so of the 500-odd partnerships surveyed have been in existence as much as twelve years. The great majority of them have been formed within the last six years.

by providing for dissolution first and then adding pertinent current features. We haven't had to change anything."

¶ From a Connecticut man: "Thus far, our written contract —which is based on MEDICAL ECONOMICS' past articles—hasn't produced trouble. On the contrary, by carefully detailing all possible aspects of our professional association, it has kept misunderstandings to a minimum."

¶ From the senior partner in a Washington State office: "We have no problems. I wrote the agreement. Although my partner doesn't understand it, he trusts me and the attorney who assisted me in drawing it up. It's a year old and so far it doesn't need changing."

That last arrangement is uncommon, perhaps unique. But,

Which Partner Is the Boss?

About half the surveyed partnerships are set up so that the partners are on equal footing. The other 50 per cent have one or more men as senior partners, the others as juniors.

for the time being at least, it's apparently working.

4. The partners should share the workload as equally as possible.

For one reason or another, one physician may see fewer patients than his partner, and both men may be perfectly satisfied. But by and large, the respondents say they try to even out their medical duties. This is in line with an observation recently made by Chester Porterfield, vice president of Medical Management Control in San Francisco. Said he:

"One way to assure the future of your partnership is to share all patients and their loyalties. This may take the form of regular al-

The Most Popular Combinations

About one in three of the surveyed partnerships consists of two or more G.P.s. About one in seven consists of two or more surgeons. Two or more OB/Gyn. men and two or more pediatricians constitute the next most frequent combinations. Mixed partnerships (men in two different fields) are quite uncommon.

ternation of visits; or the sharing may be less formal, possibly by subspecialization. The goal is to achieve acceptance of both doctors by all patients. There can be no question of piracy if patients are loyal to the practice rather than to one physician. *This principle of interchangeability is the most important factor in building a successful partnership."*

In apparent support of this view, the great majority of the studied partnerships distribute new patients to whoever is free or on duty, or on a basis of rotation. (It's somewhat different with established patients. In more than half the partnerships, each physician considers a certain number of such individuals as his own.)

How They Share Work

What's more, regardless of whether the doctors are on equal footing or on a senior-junior basis, most of them report that they alternate house calls and night and week-end chores. Often they alternate hospital rounds as well, although some make them together.

Such division of the workload is one of the biggest advantages to partnership practice, maintains a Wyoming ophthalmologist. "Having a partner gives me

real relief from the feeling I used to have that all those people out there in my waiting room had to be seen by me alone," he explains.

"Today," adds a Tennessee pediatrician, "I had a child with a fever of 105 degrees. Although laboratory studies indicated no serious disease, no conclusive diagnosis could be reached. The parents were frantic. When my partner looked the child over and gave the parents an extra opinion and added reassurance, he helped me share the load at the moment."

5. Both partners should be emotionally mature.

"Maturity" is a widely used but hard-to-define term. Perhaps an Arkansas G.P. sums it up best when he says: "We've grown-up in that we've put the partnership first and individualism second." More specifically, emotional maturity seems to involve a sense of tolerance and a sense of humor.

For example, here's how a Pennsylvania OB/Gyn. man puts it: "Partnership is like being married. Small habits do rub the wrong way. When that happens, we just say: 'Something's bothering me.' Then we discuss the matter."

And a Kentucky anesthesiolo-

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This new timed-release tablet provides:

- ***...the superior decongestant and antihistaminic action of Triaminic***
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Each* TUSSAGESIC *Tablet contains:

TRIAMINIC®	50 mg.
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Terpin hydrate	180 mg.
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Tussagesic timed-release tablets provide relief in minutes, which lasts for hours

first—3 to 4 hours of relief from the outer layer

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Dosage: 1 tablet in the morning, mid-afternoon, and evening, if needed. Should be swallowed whole to preserve the timed-release action.
Suspension: Adults—1-2 tsp. every 3-4 hours; Children 6-12 years old—1 tsp. every 3-4 hours; Children under 6—dosage in proportion.

NEW Tussagesic*

*Contains TRIAMINIC to STOP running noses and open stuffed noses orally

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gist reports: "I believe our partnership has worked well because we're not restricted, because we meet each other at least 60 per cent of the way, and because we support each other regardless of what either of us may hear about the other."

You're on the right path, according to a number of successful respondents, if you can overlook your partner's minor failings as long as they don't interfere with the success of your partnership. Consider the following comment from a West Virginia neurosurgeon:

"Junior is slow. This is partly due to his newness, partly due to his nature. But his pleasing personality and professional reliability more than compensate for this weakness."

An occasional respondent admits his office is stirred up now and then by feuding wives. Even here, however, tolerance and a sense of humor can help solve the problem. A Kansas EENT man remarks dryly:

"We've done nothing at all about our wives' bickering. Luckily, we agree among ourselves that treatment with a flat board with perforations near the distal end would be apropos."

There you have five important factors that have helped several

hundred small partnerships click. A sixth factor seems worth mentioning, too, even though only a few of the surveyed doctors comment on it:

It sometimes seems advisable to keep social contacts among partners to a minimum. All the respondents who do this believe their combined practices are the better for it.

In a few cases, they claim to have no social contacts at all. Says a Pennsylvania man: "My partner and I are about the same age, have known each other twenty years, and think alike medically. But we have *no* hobbies, sports, or social activities in common. I think this is the most important factor in our integration."

More often, the partners apparently get together socially now and then, but are careful not to overdo it. Says a New Jersey pediatrician: "I've found it's best if our families remain friendly—but if they don't fraternize too much."

END

Subject Index to

Medical Economics

July Through December, 1958

Back copies of MEDICAL ECONOMICS, containing the articles and items in the following list, may be purchased, as long as the supply lasts, at the established back-copy price of 50 cents each. Individual listings show title, date of issue, and page number. Italics denote full-length articles of one page or more; other listings refer to news items and letters of lasting interest.

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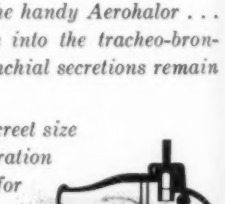
Your asthmatics will appreciate the Aerohalor's discreet size and shape, which permits unobtrusive self-administration of Norisodrine. Too, this same compactness makes for convenient carrying in purse or pocket.



With dosage accurately adjusted, side effects are seldom experienced. Abbott

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new survey reveals

Orinase* is even safer than aspirin!

Therapeutically, a hypoglycemic agent and an analgesic are obviously dissimilar in the extreme. We selected aspirin as a basis of comparison simply because it is so widely used and so highly regarded. The purpose of this comparison is not to disparage the unquestioned value of aspirin in medicine, but rather to dramatize the remarkable safety of Orinase.

The results of a survey which involved a comprehensive, objective analysis of Orinase therapy in 9,168 diabetics treated in this country by 420 clinicians, over periods of up to 28 months, were presented recently at the Third Congress of the International Diabetes Federation in Düsseldorf, Germany.

Insofar as safety is concerned, this survey confirmed the fact that Orinase's remarkable freedom from toxicity makes it almost unique among drugs of therapeutic importance. Among these 9,168 patients, there was not a single instance of serious toxic reaction, and the total incidence of side effects (including even those not traceable to Orinase, plus those of insufficient severity to necessitate cessation of therapy) was only *3.2 per cent*.

Even the ubiquitous aspirin cannot match this safety record. The lowest incidence of side effects from aspirin reported in the last 5 years, based on an exhaustive survey of the literature, was *5 per cent*. And even this incidence occurred among some 300 people representing an average cross section of the community, without reference to their previous medical history.[1]

In short, the *maximum* incidence of side effects with Orinase is less than the *minimum* incidence of side effects with aspirin, on dosage levels in the 1 to 1.5 gram range. In other words, even *if* aspirin possessed hypoglycemic activity equivalent to that of Orinase (which it of course does not), Orinase would *still* be the drug of choice, because of its greater safety.

*TRADEMARK, REG. U.S. PAT. OFF. — TOLBUTAMIDE, UPJOHN

1. Muir, A., and Cossar, I. A.: Brit. M. J. II:7-12 (July 2) 1955.

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Low Dosage KYNEX* for G.U. Infections

Sulfamethoxypyridazine Lederle

Unusual Antibacterial and Anti-infective Properties—More soluble in acid urine[1] . . . higher and better sustained plasma levels than any other known and useful antibacterial sulfonamide.[2]

Unprecedented Low Dosage—Less sulfa for the kidney to cope with . . . yet fully effective. A single daily dose of 0.5 to 1.0 Gm. maintains higher plasma levels than 4 to 6 Gm. daily of other sulfonamides—a notable asset in prolonged therapy.[2]

Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

KYNEX—WHEREVER SULFA THERAPY IS INDICATED

Tablets: Each tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24 and 100 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottle of 4 fl. oz.

references:

1. Grieble, H. G., and Jackson, G. G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958.
2. Editorial: *New England J. Med.* 258:48-49, 1958.

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*Reg. U. S. Pat. Off.

poor substitute for companionship

Many housewives, when they feel the need for companionship, ask a friend in for coffee. Others substitute eating. Instead of a chat, they take a nibble. The result: overweight.

'Dexamyl' *Spansule* sustained release capsules can help such patients in two ways:

- provide daylong appetite control—both between meals and at mealtimes.
- relieve the underlying tension and anxiety that so often cause overeating.

Dexamyl* (Dexedrine† plus amobarbital) Spansule* sustained release capsules are available in two dosage strengths: No. 2 (standard strength) and No. 1 (lower strength).

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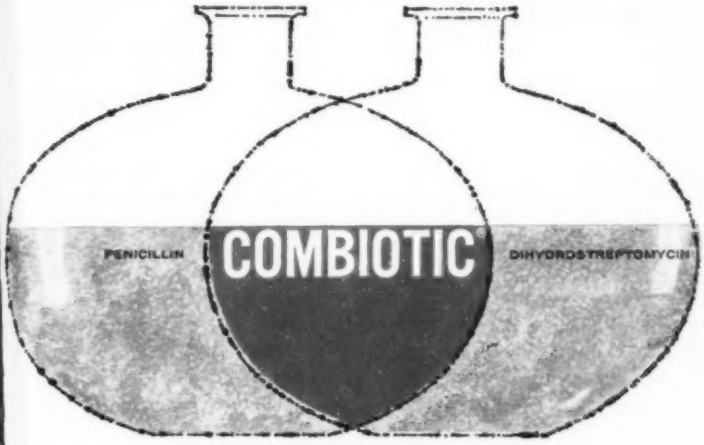

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DECREASE COST OF MEDICATION
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"The combination of penicillin with streptomycin [as in Combiotic] broadened the spectrum of activity . . . most important, made it possible, because of an additive antimicrobial effect, to treat infections not susceptible to the individual drugs alone."[1]

Available in three formulations for greater convenience and individual therapy:

COMBIOTIC P-S (dry powder) 0.5 Gram Formula
100,000 units penicillin G procaine crystalline and 100,000 units buffered penicillin G potassium crystalline plus 0.5 Gm. dihydrostreptomycin sulfate in each dose. Available in one and five dose vials.

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Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N.Y.

[1] Welch, H.: Antibiotic Med. 3:375. 1956

Memo

From the Editors

Coming in January

Doctors are still talking about "Going Broke on $45,000 a Year," an article that MEDICAL ECONOMICS published three months ago. Typical comment from an M.D. in Atlanta, Ga., who telephoned us just recently after having discussed it at lunch with two medical friends:

"My figures are much lower than those in your case history, but my feelings are almost exactly the same. My earnings seem to slip right through my family's fingers! We're spending too much and saving too little. Isn't there some really practical way to conserve more of that money as it passes through our hands?"

Yes, there is such a way—and it bears little resemblance to the usual family budgets. You know the reasons why *those* won't work. Your income is irregular, almost unpredictable from month to month. You're hit by large lump-sum expenses six or eight times a year. You're not like wage-earners for whom budgeting is made easy by regular salaries and painless payroll deductions for taxes, etc.

What, then, is a sensible spending plan for a medical family? The next issue of MEDICAL ECONOMICS describes such a plan in detail. It has been tested by several hundred doctors, and it works. It's the best insurance we know of against "going broke on $45,000 a year."

Best of all, it's a money-management method you can apply for yourself. You separate your fixed commitments from your family's spendable income; you make your wife the manager of the latter; you help her hold such spending down to last year's level; you channel all uncommitted new funds into investments and savings.

That's the plan in essence, but there's much more to it—including sample spending patterns and a "form chart for family spending." You'll find them all in the January 5 issue.

Which illustrates once again that MEDICAL ECONOMICS' scope is not narrowly limited to practice-connected business problems. Instead, its scope is just as broad as the modern doctor's economic interests. Further evidence of this in our forthcoming issues ranges from "A Ten-Second Test for Your Will" to "If You're Tempted to Invest in Alaska"; from "It Pays to Transfer Ownership of Your Life Insurance" to "When Should You Trade In Your Car?" END

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